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ABSTRACT

This survey report presents information on 20 treatment programs in 12 states which are directly concerned with the existing sexual problems and future behavior of correctional inmates, probationers, and parolees. Three additional programs which are no longer in operation, but have considerable historical interest, are also described. The programs reviewed fall into two broad categories: institutions, mental hospitals, or special institutions for sex offenders; and community-based programs for offenders (including probationers and parolees) living in the community. No attempt is made to evaluate each program individually, or to rank them comparatively. Rather, report recommendations call attention to the wide range of alternatives being explored, and from which those planning to launch additional programs can make a selection appropriate to their problems, goals, and resources. Excluded from this survey is a wide range of treatment programs, both institutional and community, which are available to offenders generally, including sex offenders, but which are not tailored to the specifically sexual problems of sex offenders. Appended material includes descriptions of nine additional treatment programs, an evaluation of sex offender treatment programs, and a state-by-state list of directors of treatment programs for sex offenders. A list of bibliographic references is provided. (Author)

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TREATMENT PROGRAMS FOR SEX OFFENDERS

By

EDWARD M. BRECHER

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ABSTRACT

What should be done about sex offenders after they have been sentenced and turned over to the correctional system?

Nothing in particular is being done about the vast majority of them and little or no attention is being paid to the particular factors which made these men sex offenders—and which may (or may not) lead them to commit future sex offenses. There are, however, some notable exceptions. This survey report presents information on 20 treatment programs in 12 states which are directly concerned with the existing sexual problems and future behavior of correctional inmates, probationers, and parolees. Three additional programs which are no longer in operation, but have considerable historical interest, are also described. The programs reviewed fall into two broad categories: institutions, mental hospitals, or special institutions for sex offenders; and community-based programs for offenders (including probationers and parolees) living in the community. No attempt is made to evaluate each program individually, or to rank them comparatively. Rather, report recommendations call attention to the wide range of alternatives being explored, and from which those planning to launch additional programs can make a selection appropriate to their problems, goals, and resources. Excluded from this survey are a wide range of treatment programs, both institutional and community, which are available to offenders generally, including sex offenders, but which are not tailored to the specifically sexual problems of sex offenders. Appended material include descriptions of nine additional treatment programs, an evaluation of sex offender treatment programs, and a state-by-state list of directors of treatment programs for sex offenders. A list of bibliographic references is provided.

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ACKNOWLEDGMENTS

This survey of treatment programs for sex offenders covers 20 existing programs and three which have been discontinued. During the past year and a half, I visited all 20 of the existing programs and talked with their directors and staffs.[1] My primary indebtedness is to these men and women who work with sex offenders directly. The names of the program directors and the addresses of the programs are listed in Appendix C, page 93. So far as I have been able to determine, these 20 programs were the only ones in operation during 1976.

The program directors and staff members I visited were without exception astonished to know that there were 20 programs currently in operation; they knew only a few at first hand and a few more by reputation. The other programs, mostly small and new, had escaped their attention. They accordingly saw the present survey as a welcome opportunity to learn about recent developments in other parts of the country, and to inform the outside public of their own programs. My visits, as a result, were not seen as intrusions on an already overcrowded work schedule but as a welcome way to bring together the first national overview of the sex offender treatment movement.

Three pioneers in the field who are no longer actively associated with treatment programs were also visited, and helped to provide a historical perspective: Dr. Asher Pacht of the Wisconsin Department of Corrections, Dr. Seymour L. Halleck of the University of North Carolina, and Dr. H. L. P. Resnik of College Park, Maryland. My talks with them impressed me with the many puritanical restrictions under which treatment programs operated during the 1950's and 1960's, and with the rapid progress being made under the much less restrictive circumstances prevailing since 1972 (see pp. 5–7).

A psychologist and sociologist served as an "advisory panel" for this project: Dr. Jennifer James of the University of Washington, Seattle, and Dr. John Gagnon of the State University of New York at Stony Brook. Their advice and suggestions are gratefully acknowledged—but they are not responsible for any of the statements made.

Joan Gauche of the District of Columbia bar surveyed state laws concerning sex offenders as well as recent laws decriminalizing sexual acts among consenting adults in private, and advised on other portions of the study.

My thanks are similarly due to the more than a hundred sex offenders with whom I rapped individually, in small groups, and in large groups at treatment centers throughout the county. These informal rap sessions, sometimes stretching far into the night, buttressed the evidence from more formal sources: many sex offenders, including many rapist and child molesters, can in fact be rehabilitated through soundly planned, staffed, and administered treatment programs.

Others who have come to know sex offenders within the treatment setting, let me add, have been similarly impressed. The effect is quite different from the effect of rapping with ordinary criminal offenders in a conventional correctional institution. Indeed, today's treatment programs have been able to attract and hold

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[1] Two new programs were launched in Gainesville, Florida, and Edina, Minnesota, following the conclusion of my survey. They are not described in the text but are listed in Appendix C.

outstanding directors and staffs primarily because of the sense of accomplishment which comes from watching sex offenders mature, develop skills, and assume responsibilities as the program's effects become visible.

Three of the programs here reviewed are headed by women (see Appendix C), and almost all of them employ women in positions of responsibility. I made a particular effort to talk as fully and frankly as possible with these women—all of whom share a common detestation of rape, child molestation, and other sex offenses, and all of whom see themselves as potential rape victims. *Their* sense that treatment programs make sense and warrant public support impressed me particularly, for I could hardly dismiss them as being "soft on rape" or as blinded by male chauvinist prejudices.

In addition to talks with women staff members, I benefited particularly from talks with Ms. Carole Anne Searle of the Canadian Penitentiary Service; Ms. Deborah S. Anderson, Director, Sexual Assault Services, Office of the Hennepin County Attorney, Minneapolis, Minn.; Ms. Bart Delin of the American Association of University Women's Committee on Sex Offender Treatment Programs, Minneapolis; Ms. Fay Honey Knopp of Prison Research Education Action Projects in Westport, Connecticut; and Ms. Lucy Rupe Watt of Rochester, Indiana, who served for more than five years as a one-day-a-week volunteer in the sex offender treatment program at Fort Steilacoom, Washington. I also visited in several cities with the women in charge of rape education centers, rape treatment centers, and service programs for rape victims, asking their views of the treatment program in their vicinity. Without exception, these women professionally concerned with rape and familiar with a local treatment program for sex offenders spoke well of it.

In the course of research for this survey, I was privileged to participate in a variety of activities concerned with the problems of rape and other sex offenses:

- A treatment program subcommittee of the Sex Crimes Analysis Unit, Connecticut State Police, which meets periodically under the chairmanship of Lieutenant Doris Hughes, director of Connecticut's Sex Crimes Analysis Unit.
- A two-day conference on "Sexual Assault: The Lonely Crime," held in Minneapolis November 9-10, 1976, under the sponsorship of the Minnesota Program for Victims of Sexual Assault, Ms. Peggy Spektor, Director.
- A Joint Project Advisory Committee which is planning a series of twelve regional conferences on rape and sexual assault to be held during 1977 and 1978. The conferences will be under the auspices of the National Center for the Prevention and Control of Rape, National Institute of Mental Health, Rockville, Maryland, and will be administered by the Verve Research Corporation. Treatment programs for sex offenders will be one of the topics considered at several of the regional conferences.
- A study of sex offender treatment programs currently being made by Correctional Service of Minnesota for the Minnesota Department of Corrections, under a mandate of the Minnesota Legislature. Out of this study will emerge the first statewide plan for sex offender treatment programs, to be presented to the legislature in 1977 (see pp. 11–12). Dr. Thomas C. Correll of Correctional Service of Minnesota is in charge of this study.
- The First Annual Conference on the Evaluation and Treatment of Sexual Aggressives, held in Memphis, Tennessee, April 14-16, 1977. The meeting was chaired by Dr. Gene G. Abel, Department of Psychiatry, University of Tennessee Center for the Health Sciences. It was funded by the National Center for the Prevention and Control of Rape. This meeting was the first opportunity for the directors of the treatment programs here described to

meet with one another and with researchers and women concerned with rape, to exchange views and data and to plan for future cooperation. A Second National Conference, again sponsored by the National Center for the Prevention and Control of Rape, is planned for 1978.

While the bulk of the data here presented came from my visits to treatment programs, interviews with directors, staffs, sex offenders, and others, and participation in the activities listed, I also made full use of the relatively meager supply of reports and papers, published and unpublished, concerning these programs; these sources are listed in the Bibliography (pages 95–98).

As a check on accuracy, portions of this study were circulated in manuscript form to directors of all of the programs described and to most of the other persons listed above. Their comments and corrections were enormously helpful. I am particularly indebted to Dr. Pacht, Ms. Searle, Ms. Knopp, Dr. Resnik and Audrey Resnik, R.N., Dr. Gloria Levin of the National Center for the Prevention and Control of Rape, and Dr. Suzanne M. Sgroi, Connecticut Child Abuse and Neglect Demonstration Center, Hartford, for their comments on portions of the manuscript. Dr. Daniel Glasser of the University of Southern California, who prepared Appendix B on the Evaluation of Sex Offender Treatment Programs (pages 85–92), also reviewed the manuscript and made useful suggestions. Any remaining errors and all interpretations are, of course, my responsibility.

Virginia Brecher prepared the Bibliography, typed and retyped the manuscript, and made helpful editorial suggestions.

Raymond S. Olsen of the American Correctional Association and Louis G. Biondi of the Law Enforcement Assistance Administration watched over this project and guided it from its origins early in 1975 to the final editing in February 1977. My indebtedness to them both is very great.

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PART I. GENERAL CONSIDERATIONS

1.1. Scope of This Survey

Are sex offenders being let off too easily in American courts, or are they being punished too harshly? Are some sex offenders serving terms in correctional institutions who might better be treated on probation? Are some who should be incarcerated being released on probation? Are sentences too long or too short? Are incarcerated sex offenders being paroled too soon or is parole too long delayed? Should unconventional approaches—castration, for example—be tried?

Important as they are, questions such as these are *not* the primary concern of this survey of treatment programs. Rather this survey starts with the facts of sentencing as they now exist. A substantial number of sex offenders are today in fact locked up in correctional institutions, and a somewhat larger number are in fact out on probation or parole. What should be done about them *after* they have been sentenced and turned over to the correctional system?

Currently, nothing in particular is being done about the vast majority of sentenced sex offenders. Those serving time in correctional institutions are lodged in the same cell blocks as those incarcerated for non-sex offenses, and are subjected to the same correctional routines. Those out on probation and parole are with few exceptions treated like other probationers and parolees. Little or no attention is paid to the particular factors which made these men *sex* offenders—and which may (or may not) lead them to commit future sex offenses.

There are, however, some notable exceptions. In the course of research for this survey, 20 treatment programs in 12 states have been identified and visited—programs which are directly concerned with the current sexual problems and future sexual behavior of correctional inmates, probationers, and parolees. Three additional programs which are no longer in operation but have considerable historical interest are also described.

A few programs now in operation may have been missed; if so, they are almost certainly new, small, and little known outside their own communities.

Sixteen of the 20 existing programs here described are less than six years old. Most of them are small. They are treating only a very small proportion of sentenced sex offenders. But, for two reasons, they are of national significance.

First, these 20 programs are gaining fresh insights into the nature of the sex offenses with which society is currently concerned—and into the life histories of the men who are committing those offenses. The insights available from the treatment programs can be secured in no other way. What the programs have been learning about sex offenders may prove of very great importance hereafter in planning for the prevention of future sex offenses, in modernizing our laws governing sex offenses, and in designing additional treatment programs for sex offenders.

Second, many of these programs have developed within the past few years a remarkable range of sensible, hopeful, and innovative approaches to the treatment of sex offenders—approaches which are significantly altering the lives of the men undergoing treatment. The men themselves are certainly benefiting; and there is considerable likelihood that society will also benefit through fewer subsequent sex offenses.

The rich array of innovative approaches unearthed in the course of this survey came as a surprise to its author and to authorities on sex offenses whom he consulted. This is because most of the programs have been operating quietly, with a minimum of publicity even in their own communities. Only a few have been even briefly described in the published literature. Even workers in a particular treatment program have little knowledge of what is being accomplished or attempted in the other 19 programs. No one before has made the rounds of the programs to observe them in perspective.

This pioneering survey, accordingly, is designed primarily to bring news of some remarkable recent developments both to the concerned public and to those professionally concerned with sex offenses. No attempt will be made to *evaluate* each program individually, or to rank them comparatively. Rather, the recommendations in Part V will call attention to the wide range of alternatives which are currently being explored, and from which those planning to

launch additional programs can make a selection appropriate to their problems, goals, and resources.

1.2. "Sex Fiends" vs. Sex Offenders

The treatment programs here described represent a repudiation of a traditional attitude toward sex offenders still widely held by the public as well as by legislators, judges, and others in positions of influence. That traditional attitude is now 90 years old; it stems directly from the most powerful and terrifying treatise on sex offenses ever published—*Psychopathia Sexualis* (1886), by Dr. Richard von Krafft-Ebing (1840-1902).

Krafft-Ebing was the foremost psychiatric consultant to the criminal courts of his generation, repeatedly called upon to testify in sex cases by judges not only in Germany and Austria but throughout Europe. He thus had abundant opportunity to examine at first hand some of the most vicious sex criminals in human history. In *Psychopathia Sexualis*, he described these offenders and their crimes in gruesome detail—so gruesome that his case histories have left their mark on the popular consciousness throughout the Western world. His rapists, for example, were not just rapists—they mutilated, and murdered, and incinerated the bodies; they maimed and tortured and desecrated. Some details were so morbid and nauseating that Krafft-Ebing veiled them in scholarly Latin to protect the sensitivities of lay readers.

Having thus aroused feelings of horror and loathing in his readers, Krafft-Ebing then went on to describe a wide range of far less threatening offenders—the voyeur ("peeping Tom"), the exhibitionist ("flasher"), and especially the homosexual—in much the same horror-inspiring manner, all as examples of "psychopathia sexualis." This pattern of grouping non-violent sexual deviations together with the most brutal of all human acts remains with us today, enshrined in the familiar term "sex offender." The term "sexual psychopath," still found in the laws of many states, is derived directly from Krafft-Ebing's *Psychopathia Sexualis*, a reminder of his continuing and pervasive influence.

In another respect, too, Krafft-Ebing profoundly influenced subsequent thinking and legislation. He believed that the causes of sexual psychopathy are in part hereditary and in part the result of actual physical degeneracy—brain deterioration, for example. He therefore believed that *psychopathia sexualis* is incurable. Here is his explanation of why Menesclou, in one of his most gruesome cases, killed and butchered a four-year-old girl:

> . . . Convulsions at the age of nine months. Later he suffered from disturbed sleep; was nervous, and developed tardily and imperfectly. With puberty he became irritable, showed evil inclinations, was lazy, intractable, and in all trades proved to be of no use. He grew no better even in the House of Correction. He was made a Marine, but there, too, he proved useless. When he returned home he stole from his parents, and spent his time in bad company. He did not run after women, but gave himself up passionately to masturbation, and occasionally indulged in sodomy with dogs. His mother suffered from *mania menstrualis periodica*. An uncle was insane, and another a drunkard. The examination of Menesclou's brain [after his execution] showed morbid changes of the frontal lobes, of the first and second temporal convolutions, and of a part of the occipital convolutions.

Decade after decade since Krafft-Ebing wrote, rape-murders and rape-mutilations have continued to occur. There is no evidence that such crimes are either rarer or more common than in Krafft-Ebing's day; but they continue to exert a powerful hold on public attention, and to perpetuate the false notion of the "sex fiend" as the typical sex offender.

\# \# \#

A visit to a treatment program for American sex offenders in the 1970's provides a very different perspective. Those currently in treatment cannot by the widest stretch of the term be classified as "sex fiends" of the kind Krafft-Ebing described. The fraction of one percent of lust-murderers and rape-mutilators are not found in treatment programs but are immured in maximum security institutions.

Not one of the programs here described makes any claim that it can rehabilitate or safely restore to society the exceedingly small group of sex offenders—perhaps a dozen per year in the entire country—whose murders, tortures, and mutilations make newspaper headlines. Treatment programs do not want these "sex fiends," and do not get them. Rather, treatment programs are concerned with the vast bulk of sex offenders—the more than 99 percent whose offenses fall far short of the Krafft-Ebing pattern.

It is *possible*, of course, that an alumnus of one of these treatment programs may commit a lust-murder of the Krafft-Ebing type tomorrow. The same is true of an alumnus of your local high school or a member of your church choir. Treatment programs are specif-

ically designed to minimize the likelihood that an offender following treatment will commit *any* sex offense following release—either a crime of the Krafft-Ebing type or the lesser offenses these men have committed in the past.

1.3. The Common Sex Offenses

Any analysis of sex offenses is complicated by the fact that state legislatures are often too inhibited to describe specifically the acts they are seeking to punish. Thus punishment may be decreed for "lewd and lascivious conduct," "acts against nature," "carnal knowledge," "imperiling the morals of a minor," and so on. Almost any sexual activity may be prosecuted under one or another of these vague and broad rubrics. The same term, moreover, means different things in different states. Thus *sodomy*, which in many states refers primarily to male homosexual acts, may or may not also be applied to heterosexual oral or anal intercourse or to sexual contacts with animals. Highly misleading terms may be used—such as *statutory rape* for an offense which is not rape at all but sexual intercourse with a fully consenting female who has not yet reached the age of *legal* consent (18 in some states). Discussions of sex offenses are further complicated by the fact that a man charged with a serious offense such as rape may be permitted, in the course of plea-bargaining, to plead guilty to a lesser offense; hence men who are in fact rapists may be lodged in correctional institutions for such apparently non-sexual offenses as breaking and entering or assault. In the discussion which follows, we shall be considering the actual offenses committed rather than the vague legal terminology often used or the lesser offenses to which a man may plead.

Until the past few years, the term "sex offense" commonly called to mind a lust-murder of the Krafft-Ebing type. More recently, the intense and proper concern of the women's movement with rape and related crimes, such as assault with intent to commit rape, has tended to make rape the predominant sex offense in the minds of many people. Certainly rape is among the most important of the sex offenses, and it is an offense with which this survey will be continuously concerned. By far the most common sex offenses, however, are three which are rarely prosecuted: fornication, adultery, and male homosexual contact.

Fornication, which is sexual intercourse between persons not married to one another, remains a crime in most states, but is generally ignored by the law enforcement and criminal justice systems. None of the participants in the sex offender treatment programs here reviewed are there for fornication.

Adultery is sexual intercourse between two persons, at least one of whom is married to someone else. This also remains a crime in most states, rarely punished and never leading to participation in a treatment program.

Male homosexual conduct and other acts classed as *sodomy* are the most common of all sex offenses; the Kinsey reports and more recent data indicate that millions of sodomy offenses are committed each week.

These offenses were not lightly punished during past eras of American history. In the 1640's in Massachusetts, for example, "buggery"—anal intercourse with man, woman, or beast—was punishable by death for both parties. In 1648 rape also became punishable by death. Rapists whose lives were spared might be sentenced to have their nostrils slit and to wear halters around their necks. Adultery with a married or engaged woman was punishable by death for both parties; but adultery between a married man and a single, unbetrothed woman was considered mere fornication, punishable by a public whipping. Also punishable by public whipping was sexual intercourse between unmarried persons and pregnancy in unmarried women. From 5 to 20 strokes of the lash were commonly laid on—or 39 strikes for more detestable offenses.

Times have changed, however. Thirteen states at this writing have repealed their laws against sodomy—including both male homosexual acts and heterosexual oral and anal acts. Most states which have repealed their sodomy laws have similarly repealed their laws against fornication, adultery, and other sexual activities engaged in by consenting adults in private. Similar repeals are under consideration in other states. Even in states where such laws remain on the books, they are rarely enforced, and even more rarely do they lead to participation in a treatment program for sex offenders.

Laws governing public indecency and solicitation—both solicitation for prostitution and for male homosexual contact—are still enforced in many jurisdictions; but they commonly lead to fines, probation, or short sentences in local correctional institutions. Rarely if ever do they lead to participation in a sex offender treatment program.

With these enormous categories of offenses eliminated or almost eliminated, and with the very small number rape-murders, sex torture cases, and sex-dismemberments similarly eliminated as grounds for

providing treatment, there remain five categories of sex offenses which account for the overwhelming majority of treatment program participants:

Rape, attempted rape, assault with intent to rape, etc.
Child molestation
Incest
Exhibitionism and voyeurism
Miscellaneous offenses (breaking and entering, arson, etc.) in cases where there is a sexual motivation.

Rape and rape-related offenses vary in several respects. There is the rapist, for example, who first physically beats up his intended victim, and who then proceeds to the sex act only after intense physical pain has been inflicted and all resistance has been overcome. There is the rapist who holds a knife to his victim's throat, informs her that he will kill her after he has made use of her, and then, savoring fully the terror he has inspired, carries out the rape. A rather different example is a sex offender known as "Mr. M," who "was found guilty of nine separate counts of assault with intent to commit rape. . . . He admitted to over 200 assaults over a 4-year period. Mr. M would walk the streets in search of a woman walking alone at night, or would follow one off a subway or bus. He would come up from behind and place one hand on her breast and the other up her dress. His fantasy was that the victim would become [sexually] aroused and readily submit to intercourse. When she struggled or screamed he would flee."

The decision whether rapists of these and other types should be committed to a treatment program or locked up in a maximum-security institution depends in most states primarily on the sentencing judge. In general, judges tend to send to the treatment programs only those rapists who seem likely to benefit from treatment; rape with violence or with weapons is more likely to lead to a long term in a maximum-security institution without treatment—or, in some states, to a death sentence.[1]

Exhibitionism is one of the two most common sex offenses which lead to participation in a treatment program. The typical exhibitionist seeks out a woman in a lonely place, often in broad daylight, and displays his genitals to her; he may masturbate and even ejaculate in the course of his exhibiting. Some treatment programs report that as many as a third of their participants are there for exhibitionism. This is true in part because "flashing" is a common offense and in part because judges are more likely to prescribe treatment in such cases than in cases where a victim is physically assaulted. *Voyeurism* or "peeping" appears to be less common—or perhaps peepers are less commonly apprehended and prosecuted; they constitute a modest proportion of participants in treatment programs.

Child molestation, the second most common offense for which treatment is prescribed, is a broad and vague rubric covering a variety of actions involving either children or minors past puberty. Offenders who attack children violently are commonly sentenced to maximum security institutions; those found in treatment programs are usually there for the fondling of children or other non-violent behavior.

Incest is the legal term for sexual intercourse or other intimate sexual contact with a member of one's immediate family. Criminal prosecutions and convictions are very rare these days in cases involving brothers and sisters, or consenting adults in private. The incest offenders found in treatment programs are in almost all cases men convicted of having had sexual relations, usually sexual intercourse, with their children or foster children too young to give legal consent.

The *miscellaneous* offenders are mostly *fetishists* whose sexual behavior leads to a variety of offenses. Typical is the young man whose sexual arousal is dependent on soiled female undergarments and who repeatedly breaks into homes to secure such garments.

Many sex offenders in treatment programs are there following conviction and sentencing under the ordinary criminal laws. In addition, programs in some states receive offenders committed under the so-called "sexual psychopath laws." These laws provide for a wholly indefinite period of incarceration—from one day to life. Release is dependent upon a finding that a so-called "sexual psychopath" is no longer a danger to society or to himself. More than 30 states now have laws of this type on their statute books, but in many states they are not used

[1] Since 1930, at least 455 rapists have been executed in the United States—of whom 89 percent have been black. Currently, Florida and Mississippi laws provide the death sentence for the rape of minors and Georgia has the death sentence for the rape of adult women. Four men have been sentenced to death for rape in Georgia since 1973 and are in Death Row awaiting the outcome of appeals. One of these cases was argued before the Supreme Court of the United States early in 1977; in this case, seven women's organizations (including the National Organization of Women) filed a brief opposing the death sentence for rape. No decision has been announced at this writing.

at all and in other states they are used only on rare occasions.[2]

The great majority of sex offenders currently participating in treatment programs are predominantly heterosexual and are there for heterosexual offenses—though some of them, like some heterosexual non-offenders, have had occasional or incidental homosexual contacts. Most homosexual participants in treatment programs are there for sexual contacts, rarely violent, with male children or adolescents. Some are homosexual incest offenders. A few have committed homosexual rape or rape-related offenses.

Substantially all sex offenses prosecuted in the United States today (except prostitution-related offenses and offenses involving indecent stage performances) are committed by men. The only significant exceptions are rare cases of child molestation in which a woman is prosecuted along with a man, often her husband. At a rough estimate, two or three hundred males are prosecuted for sex offenses for every female prosecuted. It is possible, of course, that the ratio of offenses *committed* by females is higher than the ratio of prosecutions. The number of women enrolled in sex offender treatment programs is exceedingly small; indeed, the Washington State treatment program at Fort Steilacoom, Washington, and the program at Philadelphia General Hospital are the only two which currently have female offenders in treatment.

The vast majority of sex offenders in treatment programs are aged 18 to 35; a significant minority (mostly child molesters) are past 50.

How do the sex offenders enrolled in treatment programs differ from the remainder of sex offenders? At least five "sorting processes" serve to distinguish the two groups.

- Some sex offenses are reported to the police; others are not. Most rapes and a wide range of lesser offenses go unreported. No man ends up in a treatment program as a result of an unreported offense.
- After an offense is reported, the perpetrator may or may not be apprehended and prosecuted. Those who escape arrest and prosecution no doubt differ in significant respects from those who reach the courts.
- Of those prosecuted, a small number are found not guilty and a very large number (mostly minor offenders) receive suspended sentences or are placed on probation without assignment to a treatment program.
- Of the offenders remaining after these three basic sorting processes, judges send some to ordinary correctional institutions and others to treatment programs. Which will be sent to treatment programs depends in part on state law, in part on the judge, and in part on the availability of a treatment program.
- Finally, most treatment programs can (and do) reject or transfer to other institutions offenders they deem unsuitable for treatment. The net effect of these five sorting processes is a population of program participants from which most of the very serious offenders and most of the very minor offenders have been screened out.

1.4. Impact of New Public Policies Toward Sex

The first four American treatment programs for sex offenders were established by California in 1948, by Wisconsin in 1951, and by Massachusetts and Washington State in 1958. All four programs during their early years reflected to a considerable degree the traditional policies toward sex and toward sex offenses prevalent in the United States at that time. Those policies might be roughly summarized as decreeing that almost all sexual activities are by their nature evil and subject to criminal sanctions—except for a limited number of activities permitted between a husband and wife behind closed doors.

Since the 1950's, however, a profound change has occurred. Current policies in many jurisdictions come increasingly close to providing that *all forms of sex are legally tolerated,* with three simple exceptions:

- Acts such as rape, involving force or duress (threats)
- Sexual contacts with children
- Acts in public which are deemed a public nuisance.

Legislatures, as noted above, have recognized the new attitudes by repealing a wide variety of laws providing criminal penalties for acts between consenting adults in private. Law enforcement agencies are devoting less and less effort to enforcing laws of

[2] A recent study entitled *Psychiatry and Sex Psychopath Legislation: The 30's to the 80's,* by the Committee on Psychiatry and Law of the Group for the Advancement of Psychiatry (GAP Publication No. 98) reviews these laws and recommends their repeal. Copies are available from the Group for the Advancement of Psychiatry, 419 Park Avenue South, New York, N.Y. 10016 ($4).

this kind which remain on the statute books. The courts, too, are increasingly accepting the change from "all sex is prohibited except . . ." to "all sex is permissible except. . . ." And, as might be expected, this change in policy has had a profound impact on treatment programs for sex offenders.

One major effect has been to alter the definition of *successful* treatment, and to make success much easier to achieve. To cite the most conspicuous example, a significant minority of offenders in the early programs were male adults incarcerated for homosexual acts with other consenting adults. Successful treatment in those days meant that these men, following treatment, would no longer engage in homosexual activities. As judged by that standard, treatment almost always failed. Under today's policies, success with homosexual offenders is judged by the same standards as success with heterosexuals. Treatment of a homosexual offender (usually a child molester) is deemed successful if, following treatment, he meets the same three criteria:

(1) No use of force or duress
(2) No sexual contacts with children
(3) No acts in public which might be deemed a public nuisance.

Changes in public policy have similarly profoundly affected the treatment of heterosexual offenders. Recall, for example, the fetishist with multiple convictions for breaking and entering—crimes committed in order to secure the soiled female undergarments he needed for sexual arousal. Under today's less restrictive policies, such an offender may continue his fetish without violating any law. Strip-teasers and go-go girls in many cities do a brisk trade in their soiled undergarments—and for fetishists too remote from such cities or too shy to purchase soiled panties openly, there are mail-order sources, advertised in the underground press. Even sadism and masochism—sexual arousal through the inflicting of pain on someone else or through suffering pain or bondage—can now be engaged in with consenting partners and with negligible risk of arrest or prosecution. The police in several cities tolerate S-M bars and other meeting places where sadomasochistic adults can establish social contacts with other consenting adults; such contacts can also be secured through advertisements in the underground press.

A significant proportion of participants in treatment programs are utterly ignorant of the basic physiology of sex—for example, the physiology of female sexual arousal. Materials providing this information were deemed "pornographic" as recently as the 1950's; today they are readily and legally available and are used for sex education in a number of treatment programs—in the hope that, by helping open the doors to sexual activities which society deems acceptable, they will lessen the likelihood of post-treatment sexual behavior subject to arrest and prosecution.

The changed attitude toward masturbation has also profoundly affected some treatment programs. Many sex offenders enter these programs with stern masturbation taboos; some rarely masturbate and many feel guilty and worthless following masturbation. It is an astonishing fact that some men have committed rape repeatedly, but are too deeply guilt-laden about masturbation to perform that act. Some of the newer treatment programs do their best to *encourage* guilt-free masturbation as one alternative to illicit sexual activities. Some programs also seek to reshape the fantasies which commonly accompany masturbation—from the fantasizing of rape or other criminal acts to the fantasizing of sex acts which society deems acceptable.

A major handicap in the early treatment programs was the absence of participation by women, except rarely and in minor roles. Dr. Asher Pacht, a psychologist who headed the pioneer Wisconsin treatment program during most of its existence, commented: "It is incongruous for an individual who may have primary problems in his relationships with mature women to be sentenced to the all-male environment of the typical prison. That is hardly an ideal atmosphere for the development of the socio-sexual skills necessary for establishing such relationships." The revolutionary change in public attitudes toward sexuality since 1960 has included the rise of the women's movement and greater female freedom in the sexual sphere. As a direct result, women are today employed in large numbers in treatment programs for sex offenders, as therapists and in a variety of other significant roles. Women volunteers also participate. Three treatment programs (South Florida, Philadelphia, and Colorado State Penitentiary) are headed by women.[3]

[3] "In many cases the sexual offender is fearful of women, even hostile towards them, and therefore unable to approach them except in an abusive manner. Also many view women only as objects for sexual gratification. It is essential that the offender be given opportunity to learn differently; that he can have a normal, friendly relationship with women. This can be done only when he is placed in situations which bring him into daily contact with women who are willing to work through problems with him and participate in the role-playing socialization process. He must learn to talk to and be heard by women, discuss ideas, learn to laugh with them, argue on occasion and

Changes in public attitudes toward sexuality have made possible yet another development inconceivable when the pioneer programs were launched in the 1950's—the employment of ex-sex-offenders as therapists and in other roles. One remarkable program makes use of a team composed of a male and a female therapist; the male co-therapist is an ex-sex-offender and the female co-therapist was an incest victim during several years of her childhood and adolescence. (Both are qualified clinical psychologists as well.)

This is far from a complete catalog of the many ways in which the problem of treatment has been made easier, or of the many new treatment possibilities opened up in recent years. Others will be noted throughout this survey. These examples may be sufficient to explain, however, why a new hopefulness infuses the newer and more innovative programs, and why a review of these innovations is particularly timely today.

1.5. Therapeutic Models

The pioneer treatment programs were headed by psychiatrists or clinical psychologists, and were based on the *medical* or *psychiatric* model. Sex offenders were called *patients*, and were seen as patients; therapy was designed either to cure them or to achieve a sufficient remission of their illness so that they could be safely released. The chief forms of treatment were individual psychotherapy sessions involving one therapist and one patient, plus group psychotherapy—sessions involving one therapist and several patients. While individual and group therapy are still used in most programs, most of them are also exploring alternatives to the medical model.

Several of the programs, for example, are based on a *self-help-group* model, of which Alcoholics Anonymous is the best-known example. Several are modeled after the *therapeutic community*, as developed by Maxwell Jones in England and by Synanon and other drug treatment programs in the United States. Some programs stress *social* factors; offenders learn to function effectively and appropriately within their social group. Others stress sound *interpersonal relationships* with significant persons in their lives. An *educational* approach is included in many programs; offenders are expected to learn new sociosexual skills, new patterns of self-control, new attitudes toward family members and friends, toward sexual partners and prospective partners, and especially toward themselves.

Finally, most programs today are *eclectic;* they do not hesitate to borrow a little here and a little there to enhance their total impact on offenders. This survey of 20 programs, it is hoped, will be of particular use to these eclectic programs by calling their attention to fresh approaches being pioneered elsewhere.

All 20 of the programs are based on a firm conviction that *human beings can in fact change*, and that the environment in which a man finds himself is a major determinant of change. The traditional correctional institution is a striking example of this principle. During a year or two in such an institution, as correctional officers well know, profound changes occur in most inmates. Many become more manipulative, more concerned to achieve by hook or by crook even the pettiest advantage—an extra half-slice of bread, a position two steps closer to the head of the line. This manipulative "conning," indeed, is the badge of the "convict personality." Many inmates learn in a correctional institution to suppress their anger and their hostility—until they explode in some act of senseless violence. Inmates, in order to survive, form antisocial hierarchies in which a few dominant leaders gain control and govern in ways which maximize their own power. These and other dramatic changes in human behavior are not the *intended* result of incarceration; they are incidental side-effects of the traditional correctional environment.

By establishing an *intentionally planned environment* quite different from the environment in a traditional correctional institution, today's treatment programs for sex offenders seek to effect changes of an altogether different kind in the attitudes and behavior of their participants. They also seek, in a variety of ways reviewed below, to increase the likelihood that these changes will persist following release.

1.6. "New Directions in Treatment"

The year 1972 was in two respects a turning point in the treatment of sex offenders. Three new treatment programs were launched in that year, and twelve more in the next four years. Also in 1972, a clarion call for new approaches to the problem was published by a Maryland psychiatrist, Dr. H. L. P.

understand that they are not threatening or dangerous, thus learning that there is more to a male-female relationship than sexual confrontation. In essence, they must understand the deep truth of Ullman and Krasner's observation that extensive interpersonal relationships with women are prerequisite to normal sexual adjustment in our society."—Carole Anne Searle, Canadian Penitentiary Service, Ottawa, Canada.

Resnik, and a Pennsylvania criminologist, Professor Marvin E. Wolfgang.

Dr. Resnik, in addition to his psychoanalytic training and psychiatric experience, had been (with his wife Audrey Resnik, a psychiatric nurse-clinician) among the first trainees in the new approaches to sex therapy pioneered by Dr. William H. Masters and Virginia E. Johnson at the Reproductive Biology Research Foundation in St. Louis. He was concerned with the applicability of the Masters-Johnson approach in the therapy of sex offenders. Both Dr. Resnik and Prof. Wolfgang had been involved in planning the only scientifically controlled evaluation of a sex offender treatment program ever completed—a project in Philadelphia (see Section 4.2 below) in which sex offenders were assigned at random to either a treatment program or conventional probation. The recidivism rates for the two groups were quite low—but showed no significant advantage for the treatment program. Following that sobering experience, Drs. Resnik and Wolfgang asked themselves what other treatment possibilities existed—what new approaches developed in other fields, or never tried anywhere, might prove useful in the treatment of sex offenders. Following a series of brain-storming sessions and discussions with others in the field, they reviewed in their 1972 essay, "New Directions in Treatment," a substantial list of possibilities. Many of these possibilities are currently being tried in the newer and more innovative treatment programs for sex offenders described below.

Sex reeducation. A high proportion of sex offenders are ignorant of even the simplest facts about human sexual response, and are imbued with deeply puritanical, anti-sexual feelings. "Reeducation [of sex offenders] might be effected," Drs. Resnik and Wolfgang wrote, "by offering (1) sex anatomy lectures, (2) sexual photographs, or (3) films of normal lovemaking followed by factual sexual information and professionally supervised discussions. An opportunity to see, to talk, to exchange information, and to learn can have positive benefits by encouraging the offender to develop normal sexual attitudes and behaviors."

Participation of wives. "Rather than deprive prisoners of female sexual partners," Drs. Resnik and Wolfgang continued, "institutions should make it possible for their wives and girlfriends to visit frequently and regularly. . . . These visits could be accompanied by group marriage counseling and group discussions.

"If the offender is married, his wife can be introduced into the joint planning and execution of the treatment; if he has a girlfriend, she can be involved if she is willing to stand by him." The program might even include opportunities for sexual intercourse in a "private visitation section." As treatment progresses, this could be followed by "weekly home visits. Where distance is involved, prisoners could be transported by bus for meetings with their wives in their own home communities."

Direct confrontation. "Opportunity should be provided," Drs. Resnik and Wolfgang next suggested, "for certain impulse ridden offenders to 'act out' in a situation from which they cannot escape." Exhibitionists, for example, "might be urged to masturbate in front of, or to exhibit to, a paid female mental health worker. The offender would have an opportunity to see what response, if any, would be elicited. A direct confrontation between the reality . . . and the offender's highly structured fantasy of what the response would be should result."

Clinical use of nakedness. "An adaptation of a practice like nudism might be helpful for some," the Resnik-Wolfgang analysis continues. "Voyeurs or exhibitionists could be encouraged to join nudist camps in an effort to afford them an opportunity to look or exhibit in an entirely different context of social acceptability. Such experience, when coupled with group therapy, could bring them face to face with their own feelings about sexuality, nakedness (quite a different concept), and their own bodies. . . . Learning to be comfortable with one's own body, as well as learning to handle a sexual stimulus overload from others, could result in greater impulse control."

Personalizing the victim. "Sex offenders act as if the victims are unknown to them," Drs. Resnik and Wolfgang point out; this "depersonalization" occurs even when the victim is personally known. "This phenomenon accounts for a variety of antisocial actions ranging from the My Lai massacre to the rape of civilian women as conquests of war. A clinical approach would be to personalize the victims . . ., forcing the offenders to become aware of and reactive to their victims as individuals and human beings."

This could be accomplished in part, Drs. Resnik and Wolfgang continue, through discussions between women and offender-group members. "These females could be paid and recruited among psychiatric social workers, psychiatric nurses, clinical psychology students, psychiatric residents, and sophisticated volunteers. Specialized training programs to prepare these volunteers would be needed, as well as ongoing clinical supervisors for support. The technique could

utilize tape recordings, or be elaborated to the use of videotape or direct television communication.

"The ultimate use of these 'personalized' women would be attendance at regular meetings of prison groups within the prison. For the majority of the offenders it would be a unique opportunity for a first honest and sustained dialogue with women." Precisely such "honest and sustained dialogues" have become a commonplace of sex offender treatment programs since Drs. Resnik and Wolfgang wrote.

Use of female cotherapists. On this score, Drs. Resnik and Wolfgang recommended a therapy team composed of one male and two females. "More than one woman would be needed," they explained, "to share the stress of female isolation, antifeminine attacks, or the heightened hypersexual interest of the men." Here Drs. Resnik and Wolfgang were mistaken. Teams composed of one male and one female therapist are functioning in many programs without excessive stress on the female therapist. In one or two situations, it is true, a "token" woman sex therapist in an all-male program has complained of her isolation; but where there are several women staff members in a program, it has not proved necessary for two of them to work with a particular offender group at a particular session.

Treating sexual inadequacy. "Where sexual activity between husband and wife has been unsatisfactory," Drs. Resnik and Wolfgang state, "involvement of the wife may lead her to understand her husband's offense as a marital rather than an individual problem." This is particularly true in the very frequent cases where sexual inadequacy—either potency problems or premature ejaculation in the husband, or lack of sexual arousal or orgasm in the female—lies at the root of marital dissatisfaction.

"Masters and Johnson have reported high cure rates with a number of these conditions in a highly motivated population," Drs. Resnik and Wolfgang note. The availability of similar procedures for sex offenders and their wives might significantly affect the marital relationship and hence the sex offender's future sexual behavior.

Use of surrogate partners. But what of sex offenders who do not have wives or sexual partners willing to cooperate in a program of sex therapy? In several sex therapy programs outside the correctional system, the services of a "surrogate partner" are enlisted. These surrogates enter into a sexual relationship with an impotent or prematurely ejaculating patient for the duration of therapy, and participate with him in the sociosexual procedures prescribed by the therapist. The Resnik-Wolfgang essay discusses the possibility of the similar use of sexual surrogates in the treatment of sex offenders.

"One of the authors (Dr. Resnik) . . . believes that surrogate partnerships for sex offender rehabilitation are possible," the Resnik-Wolfgang paper states. "We know that our society is not yet at the point where it will allow a trained woman employed in a professional capacity to interact with a sex offender in a normal, pleasurable manner that can serve as a model for preferred sexual activity. Yet, this might will be the optimal treatment when the high costs and poor results of psychotherapy and incarceration are considered."

No use of sexual surrogates has as yet been reported from any treatment program for sex offenders. One case has been reported, however, of the use of a homosexual volunteer as a sexual surrogate, outside the correctional system, in the treatment of a homosexual child molester who wished to transfer his sexual interests from prepubertal male children to adult male partners (see pages 57–58).

Group therapy mix. Finally, Drs. Resnik and Wolfgang proposed that instead of therapy groups composed entirely of sex offenders plus one or two therapists, experiments be tried "with deviants and nondeviants mixed together, the number of nondeviants being greater than, or at least equal to, the number of deviants" so the nondeviants would set the tone of the sessions. The nondeviants, male and female, would be recruited as volunteers from the community. "Anxiety, guilt, shame, the pains of deviance, the rewards of conformity, and many other [themes] could be explored within this proposed setting. . . . Mixed therapy groups, indeed, might generate, and perhaps even accelerate, the process of learning a set of values that does not conflict with the culture of which both [deviants and nondeviants] are a part."

In 1972, when the Resnik-Wolfgang paper was published, many of their suggestions appeared wildly implausible—obviously unachievable on this planet in this century. The extent to which most of those suggestions are already being tried out in treatment programs here and there around the country, as described below, is a striking indication of the rate of change in American sexual attitudes and attitudes toward sex offenders during the past five years.

1.7. Why Provide Treatment?

The reason commonly given for establishing sex offender treatment programs is to reduce recidivism

rates—that is, to prevent future offenses by today's convicted offenders. Two other reasons, however, deserve at least equal stress.

One justification is research. We need to know much more about sex offenders than is currently known if we are to prevent the appearance of future cohorts of sex offenders. No better way of studying the dynamics of sex offenses has been found than through the establishment of treatment programs. Further, the knowledge arising from existing treatment programs is surely the most likely guide to the establishment of far more effective treatment programs in the future.

Treatment programs can also be justified in part as a service to sex offenders themselves. Our society provides a variety of services to a wide range of subgroups in the population—the physically ill, the mentally ill, the mentally retarded, the exceptionally bright, the very poor, and so on. Sex offenders similarly need, and many of them want and seek, treatment. The treatment they need and want should be supplied, like any other social service, for the benefit of the recipients.

The basic approach of this study is that the launching of a new treatment program can best be justified by a combination of these three motivations. Like services to other population groups, treatment services for sex offenders are a proper (though low-priority) function of our social system. The priority is greatly enhanced by our need to know more about sex offenses—how they can be prevented and how recidivism can be minimized. Finally, the need for additional programs is made even more urgent by the likelihood, or hope, that present or future treatment programs will in fact lower recidivism rates—to the benefit of society as well as of sex offenders.

Rape and child molestation are not problems about which we can afford to sit back and do nothing. Treatment programs for sex offenders are not the only societal responses to rape and child molestation. But they are among the appropriate responses; and as such deserve support along with rape education programs, rape prevention programs, victim assistance programs, and the routine activities of the criminal justice and correctional systems.

1.8. Types of Treatment Programs

The programs here reviewed fall into two broad categories: *institutional programs* for inmates held in correctional institutions, mental hospitals, or special institutions for sex offenders; and *community-based programs* for offenders (including probationers and parolees) living in the community. Some community-based programs are *public*—operated and financed by a court, probation or parole system, or other public agency; *private* community-based programs are sponsored by agencies outside the correctional system. The table below shows the distribution of existing treatment programs among these categories.

TABLE I
20 INSTITUTIONAL AND COMMUNITY PROGRAMS FOR THE TREATMENT OF SEX OFFENDERS

A. Institutional programs

(a) in correctional institutions

1. Colorado State Reformatory, Buena Vista
2. Trenton State Prison, New Jersey

(b) in state mental hospitals

3. Atascadero State Hospital, Atascadero, California
4. Patton State Hospital, Patton, California
5. Western State Hospital, Fort Steilacoom, Washington
6. South Florida State Hospital, Hollywood, Florida
7. Florida State Hospital, Chattahoochie, Florida
8. Minnesota Security Hospital, St. Peter, Minnesota

(c) in special institutions for the treatment of sex offenders

9. Treatment Center for the Diagnosis and Treatment of Sexually Dangerous Persons, Bridgewater, Massachusetts
10. Adult Diagnostic and Treatment Center, Avenel, New Jersey (formerly ROARE, Rahway, New Jersey)

B. Community-based programs

11. Child Sexual Abuse Treatment Program, Juvenile Probation Department, Santa Clara County, San Jose, California
12. Outpatient Treatment Clinic for Special Offenders, Baltimore, Maryland
13. Juvenile Sex Offender Program, Adolescent Clinic, University of Washington Hospitals, Seattle, Washington

14. SOANON (Sex Offenders Anonymous), Los Angeles, California
15. Program for Sex Offenders, Institute of Psychiatry and Law, University of Southern California, Los Angeles, California
16. SEX Offender Program at Phipps Clinic, The Johns Hopkins Hospital, Baltimore, Maryland
17. Center for Behavior Modification, Minneapolis, Minnesota
18. Alternatives House, Albuquerque, New Mexico
19. Center for Rape Concern, Philadelphia General Hospital, Philadelphia, Pennsylvania
20. Program for Sex Offenders, Department of Psychiatry, University of Tennessee Center for the Health Sciences, Memphis, Tennessee

The addresses of these programs, and the names of the current directors, will be found in Appendix C (p. 93).

While most of the community programs listed above are operated under private auspices, they accept sex offenders on probation or parole—and many of them receive public funds for the treatment of these and other offenders.

All of the 20 programs are for adult offenders except the very new program for juvenile sex offenders in Seattle.

The program of the Office of Psychohormonal Research at The Johns Hopkins Hospital in Baltimore (see page 53) is the only one of the 20 which has tried a hormonal approach.

The program at Trenton State Prison enrolls only rapists. The Santa Clara County program in California is solely for child molesters—most of them fathers or stepfathers involved in incest with their children. The other programs enroll a broad mix of offenders.

Excluded from this survey are a wide range of treatment programs, both institutional and community, which are available to offenders generally, including sex offenders—but which are not tailored to the specifically sexual problems of sex offenders.

1.9. The Need for Statewide Planning

Most of the treatment programs for sex offenders currently in operation arose, almost by accident, through the activities of one dedicated individual or one institution baffled by what to do about the sex offenders lodged in its custody. As a result, each program is concerned with only a part of the overall problem, and commonly serves only a portion of a state's needs. Minnesota is the first state which has committed itself to viewing the problem as a whole, and to planning a statewide approach to all of the many problems in the treatment of sex offenders. The pioneer study currently under way in Minnesota may become a model for similar statewide planning in other states.

The Minnesota planning began back in 1972, when psychiatrists, lawyers, and others at the University of Minnesota compiled a monumental six-volume *Report on Sex Offenders: A Sociological, Psychiatric, and Psychological Study* which reviewed both the history and the current status of sex offenders in Minnesota. Shortly thereafter, a committee of the Minnesota chapter of the American Association of University Women, chaired by Ms. Bart Delin of Minneapolis, began holding a series of regional and statewide conferences on the treatment of sex offenders—conferences which alerted the entire state to the need for action.

Aware that most of the proposals then under consideration were piecemeal, the Minnesota Department of Corrections contracted with a non-profit organization, Correctional Service of Minnesota, to draft a comprehensive statewide plan covering all aspects of sex offender treatment. Funds were provided by the Law Enforcement Assistance Administration of the U.S. Department of Justice. The contract specified that the final plan shall be submitted by August 1, 1977.

Dr. Thomas C. Correll of Correctional Service of Minnesota, in charge of preparing the plan, is currently drawing on a wide variety of resources both in Minnesota and throughout the country. He has, for example, been visiting many of the programs described in this survey, consulting with program directors and with others, and bringing visitors from other states to consult with his Minnesota associates. He has also assembled a task force of eminent Minnesotans, whose help is being sought both in preparing a plan suitable to Minnesota's circumstances and in providing needed support when the plan is completed and ready for implementation

A surprising preliminary finding of the Minnesota group concerns the many agencies within the state which are already deeply involved in providing treatment for sex offenders—mostly in isolation from one another. In addition to the state's correctional institutions, there are the state's psychiatric hospitals, probation and parole departments, police "sex

squads," prosecuting attorneys, community mental health centers, private psychiatric clinics, family service agencies, halfway houses, and even drug treatment programs (several of which also treat sex offenders). Providing leadership and cooperative approaches among these existing services may prove an important part of the ultimate Minnesota plan.

Less formal groups were meeting in Connecticut, Florida, and perhaps other states during 1976, in a similar effort to view each state's problem as a whole. The August 1977 Minnesota plan, it is hoped, may encourage other states to organize and fund the preparation, and subsequent implementation, of statewide plans for the treatment of sex offenders both in the state's institutions and in community settings.

PART II. FIVE INNOVATIVE PROGRAMS

The first two programs here described are institutional or inpatient programs for incarcerated offenders. The other three are community-based outpatient programs—one for juvenile offenders, one for incest offenders and their families, and the third serving primarily sex offenders on probation or parole.

A. The Fort Steilacoom Program

2.1. First Impressions

The Fort Steilacoom program can best be seen as it appears to a sex offender sent to the program by a state court for a 90-day observation period, during which the program will decide whether he is eligible for treatment and he will decide whether he wants treatment.[1] The observation period is prescribed by the Washington "sexual psychopath statute," and is an alternative to conviction under the state's ordinary criminal laws.

What the newly admitted offender finds at Fort Steilacoom is a population of approximately 150 sex offenders divided into 10 treatment groups. He is assigned at random to one group, which remains *his* group as long as he stays and throughout his subsequent aftercare period.

Like the rest of society, the newly admitted sex offender has a very low opinion of sex offenders; he sees them as "losers," unfit for ordinary society, laden with guilt, liars, exploiters, untrustworthy. He is therefore amazed to find, in his group of 15, several offenders who come on as competent, effective, functioning human beings—self-respecting, understanding, open, and bound to one another by ties of mutual respect, affection, and trust. In all probability, he has never experienced anything like this before—and his suspicions are aroused. These suspicions are reinforced when he notes that the same ties of respect, affection, and trust appear to bind members of the group to the treatment program's staff—including the director and associate director. What kind of a con game is this, anyway?

Fort Steilacoom has many rituals; one is the way in which a group greets a new member. Seated in a circle, each man introduces himself by name and states his offense or offenses.

"I raped three women and tried to rape five more."

"I'm a flasher—hundreds of times."

"I had sex with my daughter from the time she was eleven until she blew the whistle."

When the new man's turn comes, he finds himself quite unable to admit his offense—either to himself or to the group.

"I'm here by mistake. This chick consented and then screamed rape."

"I don't know what happened; I was dead drunk at the time. I'm an alcoholic, not a sex fiend."

The other men nod knowingly. They have heard all the alibis many times; indeed, they made the same excuses themselves, early in their treatment.

"If you're going to stay here," one of them informs the new man, "you're going to have to stop justifying."

Later in the day the newcomer observes a confrontation: thirteen of the men mercilessly confronting the fourteenth concerning what appears to be a minor pecadillo—using a saucer as an ash tray. This is a grueling experience for the target—a social disaster. The newcomer, watching and listening, shudders and decides he'd rather sit in prison. But he is at the same time enormously attracted to the group, and fantasizes being one of its leaders. Then he returns to reality. No way, he tells himself. I couldn't make it here. I'm a loser and always will be. This tension between the newcomer's distrust of the group and his desire to belong to it—really and truly belong—may continue for weeks, perhaps months.

From the first day on, the new man is told—both orally and in writing—what is expected of him. A

[1] This account is based on two visits to Fort Steilacoom (1975 and 1976), during the second of which the author of this study spent three days and nights living on the unit with offenders—plus similar observations by a Canadian criminologist, Carole Anne Searle, who lived in the Fort Steilacoom program for a much longer period. Direct observations were buttressed by published and unpublished materials listed in the Bibliography (p. 95).

handout written by one of Fort Steilacoom's ten groups begins:

> Welcome to Star Group—that is, if you have an honest desire to change your offensive habits of behavior, and if you wish to accept your share of the responsibilities which are given to this group by the hospital. If you *do not*, then you are wasting *your* time and *ours*.
>
> You are here because of your socially unacceptable sex acts—but your problems are *not* all sex. Sex is an outlet much like drinking is to an alcoholic and both can become habitual. Your problems may be many and various. In group therapy we will learn what these problems are, and why we used sex as an outlet. Some problems are: self-pity, mistrust, hostility, self-centeredness, inability to accept responsibility, inability to express yourself properly, and many others.
>
> Upon entering group you may make excuses for what you have done. But, you will discover that most of these are based on rationalizations, or on justifications. If you are inclined to be rebellious, you will probably rebel against being criticized for offensive personality traits you may have; but *sooner* or *later*, you will see them yourself. You may quickly learn why you react the way you do and begin to understand things about yourself that you may never have realized before.
>
> One of the hardest things to do is to understand yourself. We all quickly recognize the faults of others and have difficulty with seeing our own. . . .
>
> When you are letting yourself down, you are letting your group and the hospital down also. We are very proud of our group and we remain that way only with *your help*. You might remember that kindness is something that you can't give away—it comes right back—just the same as unkindness.

Much of this is meaningless to the newcomer; but as the weeks and months roll by, such attitudes *may* become the most meaningful aspects of his life.

As the newcomer adjusts to the group, he must also gradually adjust to the representative of authority within the group—not the *therapist*, as in most groups, but a staff member called the *therapy supervisor*. The theory at Fort Steilacoom is that the men accomplish their own therapy. Three of the ten therapy supervisors are women; and a newcomer to the group may thus find—perhaps for the first time in his life—that he must enter into an open, honest, meaningful relationship with an adult female. Even if he happens to draw a male therapy supervisor, he will be faced with the need to establish an open and honest relationship with the group volunteer—usually an attractive married woman in her thirties assigned to a particular group.

As part of his early indoctrination, the newcomer must learn his *responsibilities*. Here is what Star Group tells him:

> We are responsible to ourselves to know what our responsibilities are, to understand them, to accept, and to do our best to take care of them.
>
> We are each responsible, first of all, for the best reflection of the group, and this program to the public and its opinion.
>
> We are directly responsible to our therapy supervisor, and also to Dr. MacDonald, [director of the program] for any conduct on our part or observed on the part of any other member that will or could be interpreted as unacceptable to public opinion of our confinement here.
>
> We are directly responsible to the group that it be informed of any conduct that is in any way detrimental to the group, or program. . . .
>
> Any member condoning an irresponsible act or planned act will be held responsible for each act.
>
> We are responsible to all future members in that the program be continued and continues to progress. . . .

To a typical newcomer, this means that he is expected to be a stool-pigeon, or rat, or snitch—spying on his fellows and reporting their shortcomings. To men who have served time in a conventional correctional institution, this is particularly frightening; for they have been deeply indoctrinated in a code which identifies authority as the enemy, and cooperation with the enemy—"ratting"—as a severely punishable act of treason. At Fort Steilacoom, all this is turned upside down; some men—especially ex-inmates from conventional correctional institutions—cannot make the switch and are returned to court for sentencing to some other institution.

Because the program's expectations are clear and explicit, the newcomer gradually understands what is expected of him. In many cases, he decides that this is a new kind of con game which he may as well play during his 90-day observation period. So he "plays ball" with the group. He confesses just enough of his past to give the impression of frankness and openness; he joins in the confrontations,

and he seeks in other ways to be a "model prisoner." This superficial conforming, of course, is precisely the opposite of true participation—but the group is tolerant for a time. They see the newcomer's pseudo-conformity as "trying it on for size." Perhaps he'll like his new pseudo-role as a responsible group member; if so, it's a good first step. He is given much "positive feedback"—group approval and even overt praise for his new attitude.

But Fort Steilacoom is structured as a ladder in which each change in attitude and behavior is seen as the foundation for the next step upward. After a newcomer decides to "play the game," he must next learn to *stop* playing games.

At some point during the 90-day observation period, accordingly, the newcomer faces his first major confrontation. It may begin with a trivial fault—oversleeping, for example. The newcomer makes an excuse—and the fat is in the fire. Fifteen men descend upon him. Why does he always try to lie his way out of trouble? Doesn't he realize that it is precisely such behavior which makes him always a loser, always an outsider? Why can't he face up to his shortcomings and do something about them instead of always alibiing? One group member recalls that this guy did the same thing last week under similar circumstances; and another points out that in addition to making excuses, the new man has several other marks against him. The oversleeping for which he was initially confronted is soon drowned in a review of his entire behavior pattern.

Procedures such as this—and there are many others—are rendered particularly effective because each Fort Steilacoom group functions almost continuously. The members of the group all sleep on iron cots in one overcrowded dormitory. They are awakened each morning at 6 a.m. by a member of the group assigned that responsibility; often the wakeup is itself a sort of ritual, breeding a sense of comradeship in adversity. The group eats breakfast together in the hospital refectory. Then they split up for work assignments around the hospital; but often two or more group members share the same assignment. Afternoons and evenings they are mostly back in their unit together. *Formal* group meetings fill perhaps 25 hours a week; but group interaction continues throughout the other waking hours. There are also "one on one" rituals; a particular group member singles out another for a rap, a confrontation, or a discussion.

The group process is enhanced by the fact that almost all *privileges* are controlled by the group. Telephoning is one example among many. The group decides when a newcomer is ready for such privileges. If he abuses them—by talking longer than his allotted six minutes, for example—he may lose them; and he must then apply to the group for reinstatement of the privilege. Much more important, the group decides at the end of the 90-day period whether to recommend that the man be admitted for treatment. The group's recommendation must be ratified by the treatment program staff, by the hospital, and by the court; but in a high proportion of cases, it is the group decision which prevails.[2]

The man himself is present during the final discussion of his acceptability. That is a deeply moving experience. If he is rejected, the rejection is gentle. The group may feel, for example, that this man really isn't in need of a year or two at Fort Steilacoom—and that his chances are good of being released on probation when he goes back to court. Or it may conclude that he needs a less rigorously structured environment. If the man is accepted, his attention is called to the long climb up the Fort Steilacoom ladder he still has ahead of him—but the acceptance is whole-hearted. *He is made to feel that he has succeeded, and that he now belongs.*

All sex offender treatment programs agree that a feeling of inner worthlessness is the single most common attribute shared by convicted sex offenders—even those who put up a blustering front. They are already at the bottom of the barrel—so what do they have to lose? Their lack of self-control arises in considerable part out of this lack of a *stake* in society, something they may lose if they lose control. They may fantasize becoming rich and powerful; but taking the first small steps toward those or any other goals are not within their repertoire. That, at least, is the Fort Steilacoom view of the problem.

Success breeds success. The Fort Steilacoom program teaches a man—often for the first time—that he is not a bit of flotsam washed here and there by the waves, with little or no influence over his own destiny. Here, so obviously no one can miss the lesson, what happens to a man is the direct outcome of his own attitudes and actions. Acceptable behavior is immediately and continuously rewarded—

[2] Of 154 sex offenders evaluated during the 90-day observation period in fiscal 1976, 65 percent were deemed to be sexual psychopaths within the meaning of the Washington State statute and were judged to be amenable to treatment; these men entered the treatment program. An additional 22 percent were judged to be sexual psychopaths not amenable to treatment; they were not accepted for treatment. The remainder were deemed not to be sexual psychopaths.

and acceptance into the program at the end of the observation period is the first of many such earned rewards.

The offender has an option. He may decide in the course of the observation program, or at the end of it, that he would rather take his chances with sentencing under the criminal law than stay on at Fort Steilacoom. But many motives make such a choice unlikely.

In the first place, Fort Steilacoom offers offenders the possibility of getting out—if all goes well—in a period much shorter than a criminal sentence would provide. The usual period of incarceration at Fort Steilacoom is 15 to 20 months. A man may be expelled from the program and sent back to court at any time, it is true;[3] but if so, his stay at Fort Steilacoom counts as time served. And conditions at Fort Steilacoom are generally more agreeable than at conventional institutions. Thus a man may decide he wants to stay even though he distrusts the program and has no intention of honestly participating in it.

Here the group process is particularly effective. The sentencing of a sex offender ordinarily depends upon a judge who may have only a few minutes—rarely as long as an hour—to devote to an individual offender. He ordinarily has to assist him reports from one or more psychiatrists and from a probation officer, plus a man's record as it appears in the formal documents. Psychiatrists and probation officers readily concede that they can on occasion be conned; the formal record is rarely complete. Thus sentencing is sometimes—perhaps usually—a guessing game.

The Fort Steilacoom group process provides enormous barriers to conning. A man who can readily con even a skilled psychiatrist finds it hard to con 15 fellow-offenders with whom he has been living in close quarters for 168 hours a week, week after week. During his subsequent stay at Fort Steilacoom, moreover, the same process continues; about a third of those who survive the observation period are returned to court before "graduation." Thus Fort Steilacoom's successful "graduates" form a very select group among whom recidivism should be rare.

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To some critics, the "group process" at Fort Steilacoom may sound like "brainwashing," or "thought control," or "1984." In effect, according to this view, overwhelming psychological pressures are put upon participants to convert them from freely functioning human beings into automatons goose-stepping to the tune of law-and-order.

An alternative view is that the group members at Fort Steilacoom are being subjected to very much the "shaping" processes that law-abiding citizens went through during childhood and adolescence—processes designed to turn out conforming, law-abiding citizens. Having somehow escaped these processes earlier, the Fort Steilacoom "group process" is giving them a second chance. This, of course, is the view taken by the staff at Fort Steilacoom.

A choice between these two views depends in part upon the gain for the individual participant as well as for society. Clearly the Fort Steilacoom techniques could not be properly used for turning Socialists into Democrats or Communists into Republicans. The issue is not quite the same when the purpose is to turn rapists and child molesters into law-abiding citizens. A more difficult issue concerns the use of Fort Steilacoom techniques for exhibitionists, voyeurs, and fetishists.

Another approach contrasts what happens to a man at Fort Steilacoom with what could happen to the same man if he were incarcerated instead in a maximum-security correctional institution. There, too, he would have been subjected to peer pressures and procedures reminiscent of brain-washing, thought control, and 1984—but without the obvious benefits of the Fort Steilacoom experience.

The Fort Steilacoom program is clearly an effort at behavior modification—an effort to modify the behavior of rapists, child molesters, and other sex offenders in the direction of social conformity. To those who object in principle to modifying the behavior of sex offenders, there is no possible answer.

For those who object only that the *methods* of behavior modification used at Fort Steilacoom are ruthless or brutal, however, there is a very clear answer. They did not appear ruthless or brutal during a 72-hour site visit for this study; and they did not appear ruthless or brutal to other female and male observers locked up in the unit for even longer stays. Indeed, in comparison with the ambience of the typical maximum-security correctional institution, the "group process" at Fort Steilacoom appears extremely benign—not only to observers but to most participants who have experienced both.

[3] Of 89 sex offenders who terminated inpatient treatment at Fort Steilacoom during fiscal 1976, 60 graduated to work release. Most of the remaining 29 were returned to court with a negative recommendation.

2.2. History of Program

In 1951, the Washington State legislature (like many other state legislatures from 1937 on) passed a "sexual psychopath" statute, designed in part to make it easier for the state to incarcerate sex offenders and in part to hold them for longer periods than was possible under the ordinary criminal laws. As in other states, these goals were to be accomplished by calling the incarceration "treatment" rather than punishment. This, indeed, was how the concept of treatment for sex offenders entered the American correctional system.

A history of Fort Steilacoom by Dr. George J. MacDonald, psychiatrist and director of the Fort Steilacoom program from 1965 to date, and Robinson A. Williams, a social worker and associate director from 1966 to 1976, describes what happened next—a series of events common to other states as well:

> During the years 1951–58, sex offenders were committed in increasing numbers to hospitals already overcrowded with psychotic patients, badly understaffed, and not prepared to offer any special treatment to this new type of patient. These "offender-patients" were therefore segregated on maximum security wards or distributed throughout the hospital among psychotic patients on locked wards. With no treatment available and little hope of regaining their freedom [commitment could continue for life under the sexual psychopath statute], the offenders grew discontent and restless. This resulted in manipulative and disruptive behavior, frequent unauthorized leaves, and much staff anxiety and resentment which was often expressed in increased and even punitive over-control. The situation became steadily worse until a legislative investigation of hospital conditions in general in 1957–58 resulted in major reforms throughout the hospital.

The initial reform at Fort Steilacoom was grossly inadequate; a staff psychologist was assigned to hold a two-hour group therapy session with the sex offenders once a week. "Initially, therapy was nonspecific and not predicated on any stated hypothesis about the nature or course of sexually deviant behavior. Treatment was directed toward somehow developing 'insight' which was presumed to augur a change in behavior."

During the years from 1959 to 1965, under the direction of a psychiatrist, Dr. Giulio di Furia, and a psychologist, Dr. Hayden L. Mees, this meager beginning gradually led to a much more intensive program. Since adequate staff was not available to lead additional sessions, the men began holding sessions without leaders. "New staff members brought to the group the concepts of honesty with one's self and in interpersonal relationships. Responsibility for the program shifted more and more from the staff to the program participants.

> The message to the new patient was no longer, "You are sick and we (the staff) are going to treat you," but instead, "You have been an irresponsible person and this whole group will help you learn how to behave responsibly enough to be free in the community again."

Two major steps during this growth period were the selection of Fort Steilacoom as the treatment center for sex offenders from throughout the state, and the setting aside of a separate ward in the hospital for each sex offender group—so that members of the group were together throughout the week and could interact continuously. This 168-hour-a-week "total push" concept is found in only a few treatment programs.

The process of group responsibility, however, was carried too far during a period when the head of the treatment program was promoted to head the whole hospital and when his chief assistant was in the process of leaving the hospital. Some leaders among the program residents:

> established themselves as a "privileged class", more concerned with their personal comforts and perquisites than with their responsibilities to the group members and the hospital. They manipulated to avoid work or get the easiest hospital job assignments. They monopolized money-making hospital jobs; set themselves up in the most comfortable living quarters; established a private off-ward "pad" for various illegal fun and games; and engaged in petty larceny of hospital supplies. They managed this by enforcing a "no-ratting" code among the group members similar to that existing among prison inmates. . . . The Senior Leader's role had become much like that of the top prison "politician". . . . In the course of investigating a suicide attempt by one of the general members, the Senior Clinical Director became aware of the corruption and intervened to restore the program to therapeutic effectiveness.

As part of this reorganization, a psychiatrist, Dr.

George J. MacDonald, was brought in as director of the program, and devoted his full time to it. During the next few years, he and a social worker, Robinson Williams, M.S.W., who served as associate director until 1976, developed the program as it now exists.

2.3. Basic Theory of the Program

The basic theory at Fort Steilacoom has been enunciated by Dr. MacDonald and others:

> A pattern of sexual deviation is a conscious but habitual way of seeking relief from emotional stress. The offender's predatory or irresponsible behavior toward another human being, however, achieves only *temporary* relief at best, and such behavior is invariably self-defeating as it further alienates him from others and himself. [Further, the offender] perpetuates his basic problem of deep feelings of inferiority and insecurity by self-defeating habits of relating to himself and others in deceitful and anger-producing ways.

The Fort Steilacoom treatment philosophy grows directly out of this view.

> Treatment focuses on breaking up these rejection-producing behavior patterns by daily demands for rigorous self-examination, intensive involvement with others, constant demands for honest and responsible behavior, and rewards and punishments based solely on responsible behavior.

The changes demanded of a man constitute four basic "treatment objectives":

- The offender must learn to recognize his own antisocial behavior patterns.
- He must understand the origin, development, and operation of these patterns.
- He must accept responsibility for his deviant behavior and make a *commitment* to change; and
- He must develop new patterns of behavior which will gain him community acceptance—at first within the program, and subsequently in the world outside.

The Fort Steilacoom theory that sexual deviation is a self-defeating and habitual pattern of response to stress may or may not be true. Even if it is not, it performs an important therapeutic role. Most offenders are baffled by their own behavior. They do not understand themselves or the reactions of others to them. The Fort Steilacoom theory offers them an acceptable explanation—and the assurance that they can change. Thus their lives begin to make sense to themselves. Further, the theory offers a framework within which offenders and staff can, in full agreement, work to effectuate change. As changes toward greater social acceptability in fact occur, the question of the *correctness* of the theory loses cogency. The *usefulness* of the theory becomes the important consideration.

Throughout Fort Steilacoom's history, Dr. MacDonald adds:

> Three basic precepts have remained unchanged. The first is that deviant sexual behavior is *learned* behavior and therefore subject to modification if methods can be developed to break up old habit patterns and teach new ones. The second is that sex offenders, following the example set by Alcoholics Anonymous and other groups, can do a great deal to help each other overcome their deviant behavior if given the right kind of direction and guidance by staff. That belief forms the basis of the program's guided self-help approach. . . . The third precept is that the hospital's environment and the process for relearning acceptable behavior must replicate and confront the realities of living in the community as much as possible.

The same points can be made from a more familiar psychiatric perspective. The self-respecting , relatively law-abiding adults who constitute our dominant society were not born that way. They had to *learn* acceptable modes of behavior—at home, in their relationships with parents and siblings; at school; and later in the community. In the sociosexual sphere, for example, they had to learn how to talk with girls, how to play with them, how to go on dates with them, how to kiss and cuddle with them. They had to learn to be sensitive to the feelings of others, and to see themselves as others saw them. For whatever reasons—and the early childhood histories of sex offenders are replete with reasons[4]—most of the participants in a sex offender training program have failed to progress through this series of growth experiences or through key portions of the series. Fort Steilacoom offers them a second chance.

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[4] Most Fort Steilacoom sex offenders, like offenders in general, report the familiar causes of delinquency of all kinds—broken homes, brutal or impotent fathers, uncaring or overprotective mothers, physical and emotional deprivations of many kinds. A substantial portion were physically abused as children; and of these, a remarkable number were themselves the victims of sexual abuse.

Much as learning a foreign language in your 20's or 30's is far more difficult than learning your native tongue at the natural time and in the natural way, so the Fort Steilacoom type of learning is a difficult and arduous undertaking. Graduates may still speak the new language with an accent, to continue the metaphor. But the goal is not to turn out saints; it is to turn out men capable of living in society without raping, or molesting children, or otherwise behaving in ways society will not tolerate.

2.4. Some Program Details

While Fort Steilacoom places major emphasis on the group process itself for the reeducation of its offenders, it also employs a wide range of other treatment methods—a few of which will be noted here.

Therapy supervision. While each therapy group meets many hours a week with no staff member present, supervision is nevertheless close. The therapy supervisor sits in on many meetings and can visit any meeting at any time; the program director and associate director also attend some meetings. Some sessions are tape-recorded; the therapy supervisor can later play back the session or portions of it. Following each meeting without staff, the meeting leader summarizes the highlights for the therapy supervisor; and together they plan for subsequent meetings. Finally, the therapy supervisor and the director and associate director are available to any member of a group with complaints or suggestions. These supervisory measures have proved adequate since 1965 to prevent abuses of group power; but Fort Steilacoom stresses that the possibility of abuse is always present and that administrative vigilance can never be relaxed.

Work assignments. Each program participant, after the observational period, is expected to devote 15 hours or more a week to unpaid work for the benefit of the hospital.

Work in a mental hospital can be a frustrating and depressing experience, as paid employees well know. But participants in the sex offender treatment program have a place to bring their troubles—the group. How do they react to frustration on the job? To conflicts with supervisors? Do they find their old (and deviant) sex fantasies creeping back on them? The work assignments constitute an encounter with outside reality which provides much current grist for the therapy sessions.

In addition, of course, there are satisfactions to work in a mental hospital. A sex offender assigned to a geriatric ward may spend fifteen minutes a day holding the hand of a senile woman patient; after a few days she begins to recognize him, and to smile at him, and even, later on, to exchange a few words with him. He may thus, perhaps for the first time in his life, get that inner glow that comes from knowing that he has indeed been of service to another human being worse off than himself. That is one of the roots of self-respect and self-esteem; and it is a powerful factor in the social rehabilitation of a sex offender.

Couples therapy. About half of the men admitted to Fort Steilacoom are married. "The reactions of their wives toward the husband's sex offense varied," reports Emily Wurster Hitchens, R.N., who has worked with Fort Steilacoom offenders and their wives. "Most were shocked, some felt humiliated, others took the offense to mean that their husbands did not love them, and a few felt directly responsible for their husbands' aberrations." Some seek immediate divorce, but many do not. Fort Steilacoom makes a strenuous effort to involve wives in the treatment program.

Wives often come during visiting hours, for example, and on weekends bring their children. It is an amazing sight to see offenders—many of them incarcerated for child molestation—interacting simply and appropriately with those children; not a single untoward "incident" has ever occurred.

A feature of each unit is a "couples room" with a bed and other fittings, and with a key that locks the door from the inside. These rooms were fitted out by the wives of offenders and by community volunteers; one room is even equipped with a king-size waterbed. A married offender, when he has earned the privilege and is deemed ready for it, may spend the evening there with his wife. Also available is a cottage on the hospital grounds where a man in a later stage of his treatment may spend the weekend with his wife and children.

All of this husband-wife interaction is made more significant by a couples' group which meets one night a week. Emily Hitchens, the nurse who served for a time as co-leader of this couples' group, has described the three goals of the group: (1) to help the wife gain a better understanding and acceptance of the program so that she could support her husband's therapy; (2) to help the couple examine the communication patterns in their relationship in order to identify malfunctions which could be contributing factors in the husband's sex offense; and (3) to help the couple establish a sharing and problem-solving relationship which might be a control on the husband's behavior after his release.

Many problems are brought to the couples' group—for example: "Our son is coming home from the army. What should we tell him about his father being in a sex offender program?" The familiar principles of couples' therapy and family therapy used in other settings, Fort Steilacoom has found, can also prove useful in this setting.

Psychodrama and role-playing. It is here that the woman volunteer attached to each Fort Steilacoom group is of special value; indeed, the volunteer program was first launched in order to provide women for the female roles.[5]

One volunteer who spent five years with a Fort Steilacoom group recalls:

> I would go to the hospital each Tuesday afternoon and spend an hour with the group leaders and therapy supervisor to catch up on what had happened during the week, and to plan the afternoon program.
>
> Sometimes in the course of the afternoon I would take on the role of a rape victim and express feelings of anger and terror. Or I would portray a mother of a child who had been molested, wondering how to comfort the child after such an encounter.
>
> For most sex offenders, the victim is not a person but an object to be used. Little if any thought is given to the victim as a human being with feelings. But in these psychodramas with *me*—someone bound to the group by deep ties of mutual commitment—playing the role of victim, the men were able to share my feelings of shock, rage, terror, or whatever.

The volunteers also help to teach the elementary social graces. One man, a volunteer recalls, couldn't even speak to her or look at her early in his treatment; the only way he knew to attract her attention was to tug on a lock of her hair—behavior hardly likely to win him favor on the outside. So the volunteers rehearse with the men in their group a variety of simple procedures: how to establish eye contact, how to start a conversation, how to accompany a woman to dinner, how to eat properly and dress appropriately, and all the other simple sociosexual skills which are taken for granted in respectable society but which many of these sex offenders have missed during their first growing-up period. A man who has mastered socially acceptable ways of approaching adult women may have less need for an assaultive approach—or for sexually approaching children.

Social interactions with the women volunteers are buttressed by social interactions with a variety of other mature women—with the wives of offenders who come visiting, and who get to know other members of the husband's therapy group; with the three (out of ten) therapy supervisors who are women; and, at times, with women sex offenders who are in treatment in the program. (In recent years four women convicted of child molestation in concert with their husbands have been committed to Fort Steilacoom, and assigned at random to therapy groups.) Finally, and of great importance, there are interactions with women staff members and patients in other parts of the hospital, whom the offenders meet during their daily work assignments. For some men in the program, the Fort Steilacoom program comes closer to being a normal heterosexual environment than anything they have experienced during their lives as "loners" on the outside.

The ladder. Like Alcoholics Anonymous and numerous other self-help groups and therapeutic communities, the Fort Steilacoom program is structured as a ladder, with ten or twelve steps leading upward. The group itself determines, in consultation with its therapy supervisor, when a man is ready to move up; and the group may also demote a man one or more steps. Privileges are geared to the step a man has achieved; the higher he climbs, the more freedom of action he earns. Each man must spend at least one month on each step; hence one year is the minimum time in residence. Most men take somewhat longer to reach the top, and eligibility for release—but rarely longer than two years. Men who aren't likely to make it in that length of time are mostly sent back to court for reassignment elsewhere.

Step Seven of the ladder is particularly significant, for it makes a man eligible for election to the offices of Junior Leader and Senior Leader. Groups tend to rotate men through these offices, so that each man

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[5] "Despite the very unattractive image the public has of sex offenders, the program has managed to recruit enough volunteers for each psychotherapy group to have at least one volunteer working with it on a regular basis. The volunteers, for the most part mature and attractive young married women, participate in weekly psychodrama or sociodrama sessions designed to help the offender learn to deal with women in other than immature, selfish, or hurtful ways. As the volunteers gain experience, a number of them become directly involved in weekly group therapy sessions for married offenders and their wives. . . . Once volunteers become 'regulars,' they become so enthused with their work that the program's only problem has been setting limits on the amount of time they spend."—*Annual Report*, 1973–1974. There were 29 volunteers during fiscal 1976.

has the leadership experience when he is ready for it—a major contribution to the education of men who have always been either followers or loners, and a major contribution to their self-esteem as well. They now have something of value to lose—their leadership status.

Security is also linked to the ladder. Men on observation may not leave their locked ward alone; they must be accompanied at all times by a responsible group member. The privilege of leaving the locked ward for other parts of the hospital is earned by climbing the ladder.

Work release and outpatient treatment. Completion of the inpatient program at Fort Steilacoom is followed by a period, usually of three months, during which a man is on "work release." This means that he may leave the program five days a week to find a job and to work at it. He comes back to the program each evening and weekend, continuing to participate in the same group which was his during inpatient therapy. Following work release he spends an additional period, usually 18 months, on "outpatient status"; this means he may live out but must return one evening a week to meet with his old group. Couples therapy for a man and his wife may also continue through this period.

The value of these aftercare procedures cannot be overemphasized. During the arduous and perilous period of adjusting to the world outside, a man continues to have the support of the same group, the same therapy supervisor, and the same woman volunteer who saw him through his inpatient period. He can bring his troubles and frustrations to the group for both its critical insights and its emotional support. The tie between the man leaving for work release and the group he leaves behind is strengthened by a special ritual: the group takes up a collection out of its own pockets to provide a grubstake for the work release period.

The value of work release and outpatient status is also very great for the group left behind. The men returning from the outside each evening or each week bring back news of what it is *really* like out there, and thus substitute realism for fantasy in each man's "cognitive rehearsals" of what it will be like when his turn comes to go out.

Finally, to return to the first impressions of new men just entering the program for their observation period, the men who have already completed the program and are now on work release or outpatient status constitute role models and assurances that the newcomer, too, can "make it" if he sets his mind to it and works hard at it. The new men see the entire spectrum around them in their group sessions: other new men like themselves, losers, liars, withdrawn in their shells; plus men who have accepted the program and are beginning to make progress; plus the leaders, self-confident and looking forward to a new way of life on the outside—plus those on work release and outpatient status who are almost home free.

That array from new men to men on outpatient status is a highly impressive one—not only for newcomers to the program but for visitors as well. A visitor can literally see the difference the program has made in its members.

The number of men who commit new sex offenses while on work release or outpatient status is exceedingly low—partly, no doubt, because of the program's effectiveness, but also because the men released constitute a very selected group. No adequate followup study of alumni beyond outpatient status is available; but the omens are good. (For a further discussion of program evaluation, see Appendix B.)

2.5. Some Shortcomings

In the account above, stress has been laid on the affirmative virtues of Fort Steilacoom—and especially on those features worth study by other programs and by those planning to launch new programs. The same emphasis will be followed in the review of other programs. Brief mention should be made, however, of some Fort Steilacoom weaknesses.

- Almost all of Fort Steilacoom's successes have been with heterosexual offenders. The program receives relatively few homosexual offenders for observation, keeps few of these for treatment, and graduates even fewer. The reason may be in part the men's own unaccepting attitudes toward homosexuality and homosexuals; other factors may contribute.
- Fort Steilacoom is an open hospital. The sex offender units have locked doors; but keys are in the hands of the group leaders, and men leave the locked units for meals, for work assignments, and for other purposes. There have as a result been some escapes—at least one of them widely publicized. One result has been anxiety and hostility in the immediate vicinity of the hospital; another has been a new series of security restrictions resented both by the men and by the treatment staff; a third has been an unwillingness of some judges to send to

Fort Steilacoom men who might benefit greatly there.

- The program serves best the offenders and their families from the state's main centers of population, Seattle and Tacoma: but it also draws men from distant parts of the state for whom work release and outpatient status constitute a severe hardship. Moreover, the program may have grown beyond optimum size. The Fort Steilacoom staff itself has recommended that a similar program be established in Eastern Washington and opposes any further growth at Fort Steilacoom.

As subsequent portions of this study will demonstrate, the Fort Steilacoom model is not a panacea for the problems of all sex offenders. Other programs as well have much to offer; and many possibilities have not to date been tried out by any program. A new program may well consider adopting some Fort Steilacoom features, some features from other programs, and some which it develops on its own. Those planning a new program for operation within an institution, however, should at least give serious consideration to salient features pioneered at Fort Steilacoom.

B. The South Florida Program

2.6. Origins

The Treatment Program for Sex Offenders at the South Florida State Hospital in Hollywood, Florida, was launched in 1966 by Dr. Geraldine Boozer, a clinical psychologist, and it remains today under her direction.

Like the Fort Steilacoom program, the South Florida program is housed in a state hospital—and is an almost wholly independent enclave within the hospital which houses it. Offenders spend 168 hours a week within the sex offender treatment unit. This unit has its own nursing staff independent of the hospital staff. Correctional personnel from the rest of the hospital enter the treatment unit only on rare occasions when they are summoned.

Like Dr. MacDonald, Dr. Boozer places primary reliance on the group process; the group itself is the therapist for each of its members. Indeed, South Florida carries this principle to considerably greater extremes than Fort Steilacoom. There are no women volunteers, for example, working with the South Florida offenders. The nursing staff plays only a minor role in the unit's program. The 75 offenders in residence are divided into 5 functional groups; and most of the efforts of Dr. Boozer and her staff are focused on these groups rather than on individual offenders. Indeed, much of Dr. Boozer's effort is devoted to deemphasizing anything which, in her words, might "dilute the group process." Thus an offender immured in Dr. Boozer's unit has really only two options: he can become a loyal, striving, functioning member of his group or accept the role of antisocial outcast. Those who stubbornly choose the latter course are transferred out.

"Self-government" is a familiar concept in correctional programs today. It may be anything from a facade behind which a dictatorial administration reaches its own decisions to a genuine consultative machinery for reconciling the interests of inmates and staff. At South Florida, self-government is in fact the major governing influence within the treatment unit. Dr. Boozer genuinely believes that the group has insights richer than her own, and is quite willing to adopt its insights as her policy over a broad range of operating decisions. Recently, to cite a minor example, a program for the wives and partners of offenders was being planned. Should the staff issue the invitations or should each man invite whom he pleased? The question was put to the men. Their decision: men who wished to issue their own invitations should do so. The others should give the staff the names of those they wished the staff to invite. In this as in much more important self-government matters, Dr. Boozer did not present a plan to the group for its approval. She did not seek a confrontation between a staff view and the men's view. She was obviously and openly seeking the best solution to the problem, and saw the group as the best source of wisdom available. Her own continuous reliance on and respect for the group is clearly one of the factors which builds up the confidence and respect of the men for their group.

A trustworthy group of this kind, of course, does not arise full-blown through some magical process. At South Florida as at Fort Steilacoom, it arose through a prolonged and often difficult process.

At South Florida, the first step was taken a decade ago. Dr. Boozer's role in those days was that of a forensic psychologist for patients throughout the hospital. The sex offenders, she observed, were not in fact "mentally ill" like the other hospital patients, and did not need the usual types of therapy. Since they shared a common social problem, deviant sexual behavior, they might benefit from group discussions. Little aware of what lay ahead, she accordingly brought together a dozen sex offenders for a series of weekly group meetings.

As in other correctional settings, the assembling of a group of sex offenders had far-reaching consequences. Group solidarity, as it gradually blossomed, began to spread far beyond the confines of the therapy hours. In some respects, perhaps, it became a headache for the hospital administration. Dr. Boozer accordingly proposed and was granted a major change in structure—an independent unit within the hospital where, as at Fort Steilacoom, the group process could flourish uninterruptedly 168 hours a week. In our conclusions and recommendations below (Part V), we shall recommend a similar small-scale, step-by-step launching for other new treatment programs.

The South Florida program has one major shortcoming: its actual day-to-day operations are poorly documented. Dr. Boozer is an administrator *par excellence*—much too busy and concerned with the administration of her program to write about it; and until the addition of an associate director to her staff in 1976, there was no one else to document the program, either. Perhaps the most urgent need at South Florida is for a qualified observer capable of describing and recording the day-to-day activities of the Boozer program—both for analysis by the program itself and for the benefit of other institutions. The description which follows stresses those aspects of the South Florida program which differ from the program at Fort Steilacoom; it is based on a two-day visit to South Florida plus talks with Dr. Boozer, with the group, and with observers in the community.

2.7. Social Role of the South Florida Offender

Like Dr. MacDonald at Fort Steilacoom, Dr. Boozer at South Florida sees service to others as a major factor in the social rehabilitation of sex offenders. In both programs, this takes the form of service to patients in other parts of the hospital. In addition, service to other sex offenders and to the cause of sex offenders in general plays an important role in the South Florida program.

A steady stream of social workers, judges, legislators, police officials, probation and parole officers, reporters, and others flows through the treatment unit at South Florida. Of special importance in this stream are women from the women's movement concerned with community problems of rape and child molestation. Each visitor is introduced to the entire offender population and invited to rap with them on open terms—to ask and answer questions, to learn more about both sex offenses and the men who commit them.

The offenders participating in these rap sessions see themselves as public relations representatives of sex offenders in general, eager to make themselves understood and to encourage more enlightened approaches to the problem of sex offenses. They also see themselves in these sessions as contributing members of society, eager to help society solve the problems of sexual assault. On one dramatic occasion, police officials concerned with an unsolved rape brought the meager data available to the South Florida group; the men made numerous suggestions for ways to apprehend the offender, based on their personal knowledge of the *modus operandi* of rapists. On numerous other occasions, women from South Florida organizations concerned with rape prevention, rape education, and the treatment of rape victims have rapped with the treatment group and report that the sessions were of very great value in expanding their perspectives on the rape problem.

It isn't often that an incarcerated offender of any kind can feel that he is contributing to social well-being. Nothing contributes more to his sense of self-worth—and it is the absence of a sense of self-worth, as noted at length above, which may increase the offender's likelihood of reoffending. Behavioral restraints are weak in a man who has nothing to lose. By giving these men a sense that they are contributing members of society, dedicated to a worthy cause, the South Florida rap sessions with outsiders constitute a significant and highly innovative feature of the South Florida rehabilitation program.

At least equally important, the South Florida rap sessions have built an understanding of and respect for the treatment program in the outside community. Unlike many of the programs visited for this study, the South Florida program has thus developed an enthusiastic constituency on the outside. When sex offender issues arise in the state legislature, there are legislators who have rapped with the South Florida inmates and who can bring their insights to bear on those issues. When someone demands the death sentence or castration for all sex offenders, there are women in the women's movement and elsewhere who can and do call attention to alternative approaches to the problem. Judges who have rapped with the Fort Steilacoom group have a much better understanding of what manner of offenders should be sent there—and of who should *not* be sent. Any effort to curtail the treatment program or to slash its modest expenditures would no doubt be met with concerted opposition from respected and powerful

interests in the state. The mass media communicate at least part of this respect for the South Florida program to the public at large.

Rap sessions with the South Florida offender group are not, however, the only factor in building the prestige of the program in the outside community. Dr. Boozer herself is the other factor. As a woman personally active in the women's movement, she has managed to make her treatment program for offenders an integral part of the community anti-rape program—along with rape prevention, rape education, services to rape victims, and the law enforcement and criminal justice approaches. This integration of a sex offender treatment program into the community's other responses to rape and child molestation, along with South Florida's development of a "total push" program based on the group process, constitute South Florida's two most significant and innovative contributions to the planning and operation of treatment programs elsewhere.

2.8. Aftercare

At South Florida as at Fort Steilacoom, the inherent worth of the program can be seen by even the casual observer who compares the stance of newcomers just entering the treatment unit with the stance of men who have experienced the group process for many months and have been transformed by it. But will the transformation survive release from the program and the confronting of the overwhelming problems which a released ex-offender must face when he returns to the free community? This, of course, is a major concern of Dr. Boozer as it is of Dr. MacDonald.

One approach Dr. Boozer stresses is the "early warning signal." Neither rape nor child molestation is commonly an act of the moment, performed as a whim when all is going well. Rather, the typical offender knows in advance when the "urge" is creeping up on him. He may wake up in the morning feeling restless. As the day progresses, he may find his thoughts turning more and more often toward his "outlet"—his preferred offense. The offense itself may occur that night or next week or next month; only rarely does it occur without such a warning or "prodrome." In the course of therapy at South Florida (as at other programs), the men explore these early warning signals in an effort to recognize the prodrome at a very early stage—when the process which may lead to an offense can still be curbed or thwarted.

To cite a typical example, one child molester's *modus operandi* may be to get in line with the children at a Good Humor wagon, strike up an acquaintance with a likely child, buy him or her a Good Humor bar, and then proceed to build on that opening gambit. It doesn't take much insight for him to know that he is in trouble if he finds himself standing in line for a Good Humor bar. By then, however, it may be too late. By conscientiously exploring his *earlier* behavior, he may come upon a much more useful signal. In the course of weeks or months, an ex-child-molester may discover, he comes within earshot of the Good Humor wagon's bell many times—*but if he is simply going about his business, he doesn't actually hear it*. It is just one of the countless noises of the city to which he pays no attention.

On the day when he feels restless and out of sorts, however, he does hear the bell, and responds to it, and gets in line with his dollar bill in hand. His *early* warning signal, accordingly, is not getting into that line but consciously hearing the bell. The ex-offender who pulls himself up short when he first hears the bell rather than when he is standing in line with those attractive children may stand a better chance of curbing his subsequent behavior.

An alumnus of Dr. Boozer's treatment program, moreover, knows just what to do when he first hears that Good Humor bell—or encounters any of the other early warning signals which he has learned to recognize during his therapy at South Florida. The procedure established to help him is patterned closely on a procedure developed by Alcoholics Anonymous.

In his pocket the ex-offender carries the number of a telephone "hot line" which he can dial at any hour of the day or night. He knows from his experience in the program that the phone will be answered *only by another sex offender*. The hot line phone terminal is in the treatment unit at South Florida. Over it is a sign: "Staff keep away; this phone is to be answered only by an offender." The program alumnus has seen the phone and the sign daily for many months during his incarceration in the program; he has confidence that anything he says over that phone will not be used against him.

Posted near the phone is a list of treatment program alumni who are currently doing well in the community, and who have volunteered their services to help other alumni. When the phone rings and an offender answers it, he can put the ex-offender in touch with one of these ex-offender volunteers. The two ex-offenders can then rap on the phone, or meet and discuss the problem until the emergency fades. Manning the hotline and helping the ex-offender in

trouble contributes, of course, to the sense of self-worth of the helpers and thus contributes also to *their* rehabilitation. The ex-offender faced with an early warning signal can also reach Dr. Boozer or be put in touch with other helpful community resources.

Like Dr. MacDonald at Fort Steilacoom, Dr. Boozer is concerned that the transition from the status of incarcerated offender to the status of ex-offender free in the community not be too abrupt. The released ex-offender needs particularly intensive support during the first days and weeks on the outside. South Florida has developed several techniques for supplying this essential support.

One is the week-end furlough under supervision—the supervision of an ex-offender doing well on the outside. In a typical case, a South Florida alumnus who is living in the vicinity of the program with his wife and children, and who is still imbued with a loyalty to "his" group, may agree to supervise a still-incarcerated offender for week-end furloughs. He comes to the hospital Friday night, signs the man out, and takes him home. The man spends the weekend as house guest; the host returns the man to the program and signs him back in Sunday night—reporting when he does so on how the week-end went and what problems were encountered. Repeated furloughs under this type of supervision constitute useful rehearsals for the day of total release. The process also reinforces the self-image of the ex-offender who supervises the weekend and thus contributes his bit to the rehabilitation of others.

As a clinical psychologist, Dr. Boozer also leads a private group of sex offenders and ex-offenders meeting outside of the institution. Alumni of the South Florida program who feel the need for continued therapy can voluntarily enroll in this group—another useful bridge between the program and life on the outside for offenders who want it.

Dr. Boozer's group outside of the institution serves a second essential purpose. In a jurisdiction where the only available treatment program for sex offenders is in an institution, judges will frequently be tempted to sentence to the institution offenders who need treatment but are not in need of incarceration. The result is unnecessary incarceration—at a high cost to the taxpayers, the institution, and the offenders unnecessarily incarcerated. Judges in the South Florida area can instead place such an offender on probation—with attendance at a community treatment program such as Dr. Boozer's specified as a condition of probation. Thus the costs of unnecessary incarceration are minimized.

2.9. Miscellaneous Comments

A major asset—perhaps the major asset—of the South Florida program is its location in close proximity to the communities it serves (four counties centered on Miami, Hollywood, and Fort Lauderdale). This relative proximity of the program to its catchment area makes possible a continuing relationship between the program and its alumni, the involvement of the offender's family in his treatment, visits from family and friends which provide continuity between institution and community, and community support of the program. The numerous advantages of geographic proximity are particularly conspicuous when the South Florida program is contrasted with the sex offender treatment program at the Florida State Hospital in Chattahoochie, which serves more than 60 counties comprising the remainder of the state (see below, section A.2).

Late in 1976, both the South Florida program and the Florida State Hospital program faced a new and potentially disastrous threat. As these programs earned increasing community respect, and as public concern with sex offenses swelled, judges during 1976 began sending more and more offenders to these treatment programs rather than sentencing them to prison or probation. (Much the same process was also reported during 1976 from the program at Fort Steilacoom.) No compensating increases in building space, staff, or budgets were available. The familiar results which have ruined so many sound treatment programs in other settings—overcrowding and understaffing—were beginning to make their appearance. Thus success might itself prove destructive to the successful programs.[6]

The basic flaw, obviously, lies in the lack of coordination among judges, legislators, treatment programs, and other elements in the criminal justice and correctional systems. The need for statewide planning to provide this coordination will be stressed in this survey's recommendations in Part V, section 5.1.

C. The Santa Clara County Program

2.10. The Incest Problem

The Child Sexual Abuse Treatment Program of the Santa Clara County Juvenile Probation Department in San Jose, California, is primarily concerned with

[6] A third Florida program was opened in Gainesville too late for inclusion in this study; it is, however, listed in Appendix C.

incest offenses. It is a community-based program for families in which there has been sexual exploitation of a daughter (or, much less commonly, a son) by the father or stepfather. Many of the principles and procedures of the program, however, should prove equally applicable to other types of sex offenders with intact families.

Prior to 1971, when the program was launched, the discovery of an incest offense meant disaster not only for the offender but also for his wife, for his sexually exploited child, and for other children in the family. In a typical case, the child involved was removed from her home and lodged in a children's shelter—deprived of emotional support at the moment she needed it most. The offender was arrested and held in jail until he could secure a lawyer and raise bail; securing a lawyer might mean signing a retainer agreement at a fee ranging from $3,000 to $10,000 or even more—a bankrupting sum for most families. The offender promptly lost his job. His usual sentence was from one to fifty years' imprisonment. The wife and her remaining children commonly lost their home and went on welfare. Thus for many families, the legal processing of the incest offense was as traumatic an experience as the incest itself.

Henry Giarretto, the psychologist who founded and now directs the Santa Clara County program, has described the psychological impact of this procedure on a sexually exploited child:

> She feels alone and threatened. This is the first time she has been forcibly separated from her family. She is overwhelmed by mixed emotions of fear, guilt, and anger and convinced that she will never be able to rejoin her family or face her friends and relatives. If transferred to a foster home, she will not adjust to the new family as this would confirm her fears that she has been banished from her own family. Though often told that she was the victim of the incestuous relationship, she believes *she* is the one who is being punished. She enters a period of self-abusive behavior manifested variously through hostility, truancy, drug abuse and promiscuity.

What Giarretto calls "the explosive reaction of the criminal justice system" also produces "shock and terror" for the wife:

> She is certain her family has been destroyed. There are subtle hints that she may have condoned the incestuous affair in the questioning by police and even others she once regarded as friends. She has failed both as wife and mother. Her feelings toward her daughter alternate between jealousy and motherly concern. Her emotional state vis-a-vis her mate is also ambivalent. At first she is blinded with disgust and hate at the cruel blow he has dealt her and vows to divorce him. Her friends and relatives insist this is her only recourse. But the rest of the children begin to miss him immediately and she recognizes that on the whole, he has been a good father. She is also sharply reminded that he has been a dependable provider as she faces the shameful task of applying for welfare.

Much the same series of events, of course, follows the arrest of a husband and father for any other sex offense. Giarretto sums up: the traditional kinds of community intervention, "rather than being constructive, have the effect of a knock-out blow to a family already weakened by serious internal stresses."

The socially disruptive effects of this approach to incest were clearly seen by Santa Clara County's juvenile probation officers. Visiting a family shortly after the offense was uncovered, and again a month or two later, they could hardly fail to note the gross deterioration—much of it the result of their own procedures. In 1971, they rebelled. "There must be a better way," one of them, Eunice C. Peterson, told the probation department's psychiatric consultant, Dr. Robert S. Spitzer.

At Dr. Spitzer's suggestion, Hank Giarretto was invited to provide ten hours a week of counseling and family therapy to incest families for a limited ten-week period; the Santa Clara County program, now in its sixth year, is the direct descendant of that very modest first step.

2.11. Some Preliminary Lessons

When he met for the first time with his first incest family, Hank Giarretto recalls, it was easy to maintain his professional attitude of acceptance toward the wife and children—

> but in preparing myself for the session with the father, I read the lurid details of his sexual activities with his daughter, which included mutual oral copulation and sodomy [anal intercourse] at the age of ten. The compassionate, therapeutic attitude which I can now write about so freely and perhaps pompously, completely dissipated. I was forced to go into deep exploration of my own unconscious. . . .

Only after coming to terms with his own complex feelings about incest and child molestation, Giarretto found, was he able to function effectively with incest families. "I cannot overemphasize the importance of self-work on the part of the therapist. This is the central theme of workshops I conduct for individuals who want to help incestuous families."

Another lession Giarretto learned early during the pilot phase of the Santa Clara County program was the remarkable ease with which a father and daughter can slip into incest:

> Jim, a successful accountant, is in his mid-thirties when he becomes aware of deep boredom and disenchantment with his life. He feels stalemated in his job and his prospects for advancement are poor. There is growing estrangement between himself and his wife. She no longer seems proud of him. In fact, most of her remarks concerning his ability as a provider, father, or husband are critical and harassing. Their sexual encounters have no spark and serve only to relieve nervous tension. He fantasizes romantic liaisons with young women at work; but he has neither the skill nor courage to exploit his opportunities.
>
> Jim finds himself giving increasing attention to one daughter. Of all his children, she has always been his favorite. She is always there for him, accompanies him on errands, snuggles close beside him as they spend hours together watching TV. His wife has no interest in this pastime. At night she is either taking classes or studying with her classmates.
>
> As his daughter cuddles beside him he becomes acutely aware of her warmth and softness. At times she wiggles on his lap sensuously, somehow knowing that this gives him pleasure. He begins to caress her and "relives the delicious excitement of forbidden sex play during childhood," as one incest father expressed it. But this phase is soon engulfed by guilt feelings as the relationship gets out of hand and he finds himself making love to her as if she was a grown woman.
>
> Between episodes he chokes with self-disgust and vows to stop. But as if driven by unknown forces, he continues to press his sexual attentions on her. He now senses that she is trying to avoid him and is no longer receptive to his advances. Though he doesn't use force, he relies on his authority as parent to get her to comply. He becomes increasingly suspicious of her outside activities and the seemingly continual stream of boys who keep coming to the house. With a sinking feeling he notices that she is beginning to respond to one of the boys. He cannot control the feelings of baleful jealousy the boy evokes, or his craven attempts to stop his daughter from seeing that boy. The daughter complains to a friend, who tells *her* mother.
>
> Hence Jim's trance is suddenly shattered one evening as he returns home from work. A policeman emerges from the car parked in front of his home and informs him that he is under arrest. Numb with shame and fear, he is transported to the police station for questioning.

What kinds of families become involved in incest? This was another of the suprises during the early months of the Santa Clara County program. The older published literature on incest suggests that it occurs primarily in poverty-stricken families where housing is excessively crowded, where the parents are of subnormal intelligence, and in remote rural areas—the "Tobacco Road" stereotype. It is also alleged to be most common in non-white ethnic populations. Among the first 300 incest families in the Santa Clara County program, in contrast, the average income was over $13,000. Many were professionals, semi-professionals, and skilled blue-collar workers. The median educational level was high—12.5 years. Three-quarters of the incest families, like three-quarters of the county's population, were white.

The frequency of incest in the community also proved a surprise. During the program's first year, 36 families were referred. Three years later, the annual intake had risen to 180—with a high probability that most cases were still going unreported in a county with a population of 1.1 million.

The program developed over the past five years has two main facets—a professional staff for counseling and psychotherapy under the county's juvenile probation department, plus a self-help group, Parents United, operated by the incest families themselves.

2.12. Current Procedures

Today, immediately after the arrest of a father on an incest charge, the wife receives a phone call from one of the wives already participating in Parents United. "I've heard you have a problem in your family. We had the same problem in our family two years ago. Would you like me to come over so we can talk about it?" Almost always, the answer is yes—and salvage operations have begun. In the

course of that first woman-to-woman rap, the newly distraught wife is told of Parents United and invited to the next Thursday evening meeting.

The husband receives a similar call from one of the men in Parents United, and usually responds similarly. Among other immediate benefits, he may reconsider the advisability of bankrupting himself with an excessive legal retainer fee.

Instead of a one-to-fifty-year sentence in a maximum security institution, the incest offender today commonly receives a three-month or six-month sentence in an *open* community institution. This means in a high proportion of cases that he can keep his job during the day, returning to the institution evenings and weekends. He thus remains the family provider, and the foundations of the family are safeguarded in the event that the couple decides to stay together. The offender can also leave the open institution for attendance at the therapy program and for meetings of Parents United.

Initially, Giarretto's expectation was that he could counsel these families, like other families, using the conjoint-family-therapy model developed by Virginia Satir. He soon discovered, however, that family therapy was *not* the right place to start. "Incestuous families are badly fragmented as a result of the dysfunctional family dynamics prior to disclosure of the offense—exacerbated by the shock of disclosure." Hence individual counseling for the child, the mother, and the father separately is the first procedure used. Giarretto also discovered that the reconstructive approach was enhanced if "the family was assisted in locating community resources for pressing needs such as housing, financial assistance, legal aid, job procurement, etc. This required close collaboration between the counselor and the juvenile probation officer assigned to the case."

As the shock of disclosure is lived through and individual counseling begins to produce effects, the counsellor may begin to see mother and daughter together. Later husband and wife may be seen together, and at a still later stage father and daughter. Finally, the whole family—including the other children—come in together for conventional family therapy.

In the early counseling sessions, Giarretto reports:

> It is necessary to generate a warm, optimistic atmosphere before productive therapeutic transactions can ensue with families that have broken the incest taboo. They must be given hope, reassured that their situation is not as singular or as disabling as they have been led to believe. Feelings of despair, shame and guilt must be listened to with compassion, as natural expressions of inner states. Awareness and acceptance of current feelings, without evaluation, allows the clients to assimilate them and to move on with their lives. I know that I must continually work at developing this attitude within myself.

Giarretto recognizes that reconstructing the family is not always either possible or desirable; divorces do occur. But in a remarkable proportion of cases, close to 90 percent, husband and wife decide to make another try at it—and the program does its best to make the second try successful.

Like the Fort Steilacoom program, the Santa Clara County program finds that a major problem among sex offenders *and their families* is low self-esteem. The whole family feels that it has failed, that it is disgraced, that it has no stake in the future. Giarretto spells this out:

- A high self-concept in each of the mates is a prerequisite for a healthy marital relationship.
- High self-concepts in the parents help to engender high self-concepts in the children.
- Individuals with high self-concepts are not apt to engage others in hostile-aggressive behavior. In particular, they do not undermine the self-concepts of their mates or children through incestuous behavior.
- Individuals with low self-concepts are usually angry, disillusioned and feel they have little to lose. They are primed for behavior that is destructive to others and to themselves.
- When such persons are punished in the depersonalized manner of institutions, the low self-concept/high destructive energy syndrome is reinforced. Even when punishment serves to frustrate one type of hostile conduct, the destructive energy is diverted to another outlet or turned inward.

The Santa Clara County program accordingly devotes much of its energy to rebuilding self-esteem and a high self-concept not only in the offender but in all members of the family. "Productive case-management of the molested child and her family calls for procedures that alleviate the emotional stresses of the experience and of the punitive action by the community; enhance the processes of self-awareness and self-management; promote family unity and growth, and a sense of responsibility to society. The purpose is not to extinguish dysfunctional behavior by external devices. Rather, we try to help each client develop the habit of self-awareness (the foundation for self-esteem) and the ability to direct one's own behavior and life-style."

As one step in this process, families learn to take an inventory of their own strengths and weaknesses:

> Initially, during this exploration, I underscore the positive traits. What does the girl, for example, like about herself? What does she appreciate in other family members and the family as a whole? Before she can be motivated to work actively for personal and family growth, she must be convinced that she and the family are worth the effort. From this positive stance, the clients can then proceed to identify weaknesses and maladaptive habits that need to be improved or eliminated. These might include uncontrolled use of drugs, food, alcohol and cigarettes; hostile-aggressive behavior that interferes with progress in family, school and work relations; sexual promiscuity; inconsistent study and work habits; and typically, the inability to communicate effectively, especially with important persons in their lives.
>
> As the clients gain confidence in their search for self-knowledge, they begin to probe the painful areas connected with the incest. In what may be termed a confrontation-assimilation process, I encourage the child, father and mother as well as other family members to face and express the feelings associated with their incestuous experience. It is indicated that buried feelings (fear, guilt, shame, anger, etc.) if not confronted, will return as ghosts to harass them. The feelings cannot be denied; they will have their effect somehow. If confronted now, they will lose their power to hurt them in the future. With some clients, the pain-provoking memories can be dealt with fairly early in the therapy; with others I find it prudent to proceed more slowly.

As at Fort Steilacoom and in other programs, the Santa Clara County program places much emphasis on the need for an offender to confront his own behavior and to accept responsibility for it:

> Although I listen with compassion and understanding to the father's feelings, I will in no way condone the incestuous conduct or go along with pleas for mercy, such as, that he is cursed and forced into incest by evil forces, or that he suffers from an exotic mental disease. He eventually is induced to admit the bald fact that he was totally responsible for the incestuous advances to his daughter. No matter what the extenuating circumstances, including possible provocative behavior by his daughter, his actions betrayed his child and wife and their reliance on him as father and husband.

The wife and child, too, are encouraged to face up to their roles in the incest situation:

> As a general rule, the mother will admit eventually that she was party to the incestuous situation and must have contributed to the underlying causes. Certainly, something must have been awry in her relationships with her husband and daughter. In order to relieve the daughter of feelings of self-blame and guilt for endangering the family, she is firmly told by her mother, and as soon as possible by her father, that she was the victim of poor parenting. This step is also important for regaining her trust in her father and mother as parents. In time, however, she will confide she was not entirely a helpless victim and is gently encouraged to explore this self-revelation.

Hank Giarretto describes himself as a humanistic psychologist—drawing on the prior work of therapists like Carl Rogers, Abraham H. Maslow, Virginia Satir, Frederick Perls, Haridas Chauduri, and Eric Berne. He emphasizes in particular his reliance on a process known as psychosynthesis developed by Robert Assagioli. It is unlikely that any other program will find a director with this particular set of theories—but there is also no reason to doubt that the Santa Clara County results can be duplicated by equally skilled and dedicated therapists holding other theories.

2.13. Roles of the Courts and Correctional System

Visitors impressed with the Santa Clara County program sometimes wonder why it need be attached to the criminal justice system. Why not operate it as an independent program serving the community like any other social agency?

Giarretto is opposed to such a plan, and cites several types of evidence against abolishing the incest law and relying solely on the mental health approach.

It often happens, he points out, that a wife becomes aware of incest in her family and threatens to break up the marriage if her husband does not agree to psychiatric treatment. "The offender temporarily complies, but stops going after a few sessions. A month or two later, he resumes the sexual abuse of his daughter. In two [Santa Clara County]

cases, the fathers continued their offenses while undergoing [voluntary psychiatric] treatment. The motivating drive and the therapy were not sufficient and the troubled family was left with its problem." The "shock effect" of legal intervention alters the whole situation and provides the needed base for family restructuring.

Nor is punishment by itself enough: "In five cases in which punishment alone was employed, the deterrent effect hoped for proved utterly inadequate. After serving long sentences, the five men came to the attention of our program for repeating the offense with other daughters or step-daughters."

On the basis of Santa Clara County's experience, accordingly, Giarretto concludes:

> In all cases, the authority of the criminal justice system, and the court process, seems necessary in order to satisfy what might be termed an expiatory factor in the treatment of the offender and his family. It appears that the offender needs to know unequivocally that the community will not condone his incestuous behavior and that he must face the consequences. The victim and her mother also [derive] comfort from knowledge of the community's clear stand on incest.

From this point of view, Giarretto's major achievement has been to develop a system in which the intervention of the criminal justice system is coupled with an effective therapeutic approach. He points out, however, that the coupling requires a tempering of the criminal justice system: "All family members will do their best to frustrate the system if they anticipate that the punishment will be so severe that the family will be destroyed—that they, in turn, will become 'victims' of the criminal justice system, including the child-victim herself."

2.14. Role of "Parents United"

Early in the Santa Clara County program, at a time when he was busiest, Hank Giarretto received a phone call from a distraught and near-hysterical woman who had just learned that her husband was engaged in incest with her daughter. Unable to spare time for a prolonged discussion then and there, Giarretto arranged to have another incest-family mother—from one of the first families successfully treated—phone the distraught mother. "The ensuing conversation went on for three hours," Giarretto recalls, "and had a markedly calming effect on the new client."

That set Giarretto thinking. One feature most incest families have in common is *social isolation;* they have few friends before the incest is uncovered and fewer afterward. Why not a self-help group? A week after the three-hour phone call, "three of the more advanced mother-clients met face-to-face for the first time" in the probation offices of Santa Clara County's juvenile probation department; and "after a few more meetings, to which several other women were invited, Parents United was formally designated and launched." The group soon grew to include most of the families in therapy, began admitting offenders as well as wives, and was later joined by a second organization, Daughters United, set up by teen-age girls who had been involved in incest.

Parents United now meets one evening a week in the juvenile probation department's large and comfortable conference rooms. Like the Fort Steilacoom program, the Parents United program makes effective use of simple rituals. The meeting opens with participants sitting in a circle—perhaps 50 or 60 of them, including 8 or 10 daughters and a few sons who have been the targets of incestuous relationships with their fathers. There may also be two or three grandfathers in the circle who have molested their grandchildren. This meeting is short. It may open with a few minutes of meditation, and with a poem, a chant, or some other attention-focusing ritual.

Husbands and wives coming to their first Parents United meeting, together or separately, approach in fear and trembling. Like the rest of society, they have an extremely low opinion of incest families, and expect to meet "sex fiends"—social outcasts with whom they could not possibly establish amicable relationships. What they find is altogether different: a rather well-dressed and extremely well-behaved assemblage of families who at first sight might be mistaken for attenders at a church social in any middle-class suburb. Eight or ten members of the circle are staff members and therapists-in-training; it is quite impossible at first to distinguish the staff members from the offenders and their wives. Also present are one or two of the first three families who founded Parents United—and who, after five years, continue to see it as a worthy social cause in which they can be enormously helpful to others.

Newcomers receive handouts which describe the essential purpose of Parents United—"to assist families having a problem that involves a sex offense by enabling them to get the kind of help they need for their particular situation during the initial crisis period; by showing them they are not alone and

problems can be resolved with a positive attitude; and by encouraging them to seek proper guidance and counseling."

The Santa Clara County group has also written its own creed—quite similar in tone and feeling to the Star Group handouts to newcomers at Fort Steilacoom, quoted above:

Creed

To extend the hand of friendship, understanding, and compassion, NOT to judge or condemn.

To better our understanding of ourselves and our children through the aid of the other members and professional guidance.

To reconstruct and channel our anger and frustration in other directions, NOT on or at our children. . . .

To recognize that we do need help, we are all in the same boat, we have all been there many times.

To remember that there is no miracle answer or rapid change; it has taken us years for us to get this way.

To have patience with ourselves, again and again and again, taking each day as it comes. . . .

Hank Giarretto, like the directors of other treatment programs, is fully aware of the extent to which *playing a helpful role toward others* is a highly effective ingredient in rebuilding self-esteem and in the personal rehabilitation of the helper. Parents United is the framework within which this helping occurs. The group members seek to provide many kinds of help for newly admitted members faced with the common crises: finding jobs, baby sitters, financial and legal aid, and so on.

Much of the effectiveness of Parents United, however, is the direct result of the small-group meetings which follow the ritual of the opening circle. Attenders are free to decide which small group each will attend—an all-male group for offenders; an all-female group for wives; and an intensive group for wives and husbands together. This group is limited to five couples and gets much more deeply into the dynamics of incest and its sequelae. There is also a Daughters United group and a group for males and females who are *not* married to one another. An offender or wife may choose to attend this mixed group rather than a one-sex group. In some cases, too, an offender whose wife has split from him may bring his new woman-friend to the group. More remarkable still, some women who have split from their husbands continue to come to Parents United—either alone or with their new male friends.

It is an amazing fact of life that when human beings assemble in a therapy group—even people with very little in common—a group process is engendered which most members of such groups find intense and very helpful. When members of the group have a traumatic past experience in common, and when in addition they currently face the same practical and emotional problems, the group can play an enormously significant role in their lives. In the course of a typical Parents United evening, for example, a father may raise the question: How can I reestablish my authority and discipline over a daughter with whom for years I have had sexual relations? Every head nods; others know the problem well. One man describes how, during the past three years, he and his daughter have been able to live down the incest experience and develop a father-daughter relationship which both find rewarding. Another group member questions the terms *authority* and *discipline:* "Why do you have to be the boss? A family isn't a sweatshop with a boss and some sweated laborers." A staff member wonders whether the question shouldn't be explored next time the father and his daughter meet with their counselor. A mother asks whether the father with the question has discussed the matter directly with either his wife or his daughter. A final comment summarizes the group feeling: "Straighten out your feelings toward your daughter and her feelings toward your discipline will then take care of themselves." The responses are critical; but underneath the criticism the father worried about discipline recognizes the deep concern and emotional support the group is providing. They've been there, too. They understand.

Parents United also has a continuing concern with the many families out there in the community in which incestuous exploitation of children still continues undiscovered—and with the community prejudices against incest families which makes it so hard for them to secure jobs, housing, and other survival needs. Both concerns are expressed through a community relations program designed to make the facts about incest better known and better understood in the community. Members of Parents United have accordingly appeared with members of the professional staff at service club lunches and other public functions to tell their own stories; they have been interviewed for newspaper and magazine features and have made radio appearances. In 1976 these public relations activities were extended to include a

television series on the area's largest station. Two kinds of benefits are expected to accrue: a greater willingness of incest families to "come out of the closet", and the mobilization of broader community support, including financial support, for the program.

Staffing a program like this costs far less than incarcerating offenders in a correctional institution. Giarretto has kept costs down in part by making the Santa Clara County program a training center for graduate students in psychology, social work, family counseling, and other fields. Trainees provide much of the counseling. (Parents United is largely self-supporting, but was helped initially with a grant from the Rosenberg Foundation, a local philanthropy.)

The California legislature in 1976 enacted Assembly Bill 2288, to establish "a demonstration center for the prevention of the sexual abuse of children." Among the center's functions will be "the development of programs for city and county personnel throughout the state relating to the prevention of sexual abuse of children." It is expected that the Santa Clara County program will form the nucleus of the new statewide demonstration center; but funds have not as yet been appropriated. Members of Parents United lobbied intensively for S.B. 2288; many journeyed to the state capitol to urge its passage.

2.15. Successes and Failures

Giarretto frankly concedes that the Santa Clara County program "is not equally effective with all clients. About 10 percent of referrals will elude our efforts. They will not come in for the initial interview, or drop out soon after treatment has begun. Four couples were dismissed from the program because the father and/or his wife would not admit culpability and placed the blame entirely on the child-victim and her seductive behavior. In these instances extraordinary effort was required in the treatment of the deserted child. The four girls, after many attempts, successfully adjusted to foster homes. Three are now married and apparently doing well."

In the more than 250 families who have stuck with the program until their treatment is deemed complete and formally terminated, Giarretto reports, the recidivism rate has been zero. "No subsequent incest has been reported in any such family."

Part of this success, of course, is due to selection procedures. The Santa Clara County program can, and on occasion does, refuse to accept an offender referred for treatment. Men with a long history of molesting children to whom they are not related, for example, are commonly excluded. But there are exceptions even to this rule. Four habitual child molesters of the type commonly classified as "pedophiliacs" were accepted because they were allied to loyal wives, had good jobs, and seemed to be "good bets." None, at last account, had reoffended.

The defenses against recidivism built into the Santa Clara County program are well illustrated by the case of an offender convicted of incestuous relations with one daughter who successfully completed treatment and was released from individual therapy—but who one year later began noticing sexual arousal with another of his daughters. Three events promptly followed. The man himself called the program to ask for an appointment with a counselor. Next day the daughter he had originally molested called Giarretto and said, "Hank, I wish you would talk to Dad. I think he's acting funny with Betty." At about the same time, too, the mother voiced misgivings about her husband's increasing attentions to Betty at a group session she was attending. The father returned to therapy and did not reoffend.

Giarretto stresses the numerous benefits of the Santa Clara County program:

- Children are returned to their families sooner than under the conventional system—90 percent within the first month, 95 percent eventually.
- The self-abusive behavior of the children, usually amplified after exposure of the incestuous situation, has been reduced in both intensity and duration.
- Marriages have been saved (about 90 percent)—many confiding that their relationships are better than they were before the crisis.
- The Parents United formula is proving to members that they can become a strong voice in the community—a significant realization to those members who used to regard themselves as the pawns of civil authorities.
- The high cost of long-term incarceration of incest offenders is avoided.

Hank Giarretto urges that similar Child Sexual Abuse Treatment Programs (CSATP) be launched elsewhere:

> By working integrally with the Criminal Justice System the CSATP shows promise of developing into a model for other American communities. Each community must be given the opportunity to treat incestuous families in a manner that is neither permissive or cruelly

punitive. A national position must be taken on the incest taboo and laws enacted that are effective and consistent. The community must publicize these statutes and the penalties for violating them. To prevent incest the public must be educated to become aware of predisposing conditions and to take appropriate action. Finally, comprehensive procedures similar to the CSATP must be established in each community to treat sexually abused children and their families to enhance their chances for reconstitution and to prevent future violations.

Many aspects of the Santa Clara County program, including especially its family therapy approach, may also prove useful for the treatment of sex offenders whose offenses are not incestuous. Such a program, for example, might accept *all* sex offenders who have intact families and who are eligible for probation rather than incarceration. In addition, it might accept incarcerated sex offenders with intact families following their release on parole—and work with the families might begin prior to release of the offender. These are possibilities which will be explored more fully in Part V, Conclusions and Recommendations.

# # #

The Fort Steilacoom and South Florida institutional programs and the Santa Clara County community program have been presented here in parallel because they complement one another effectively. The question of which is better is misleading. *Both institutional and community programs are essential,* for a variety of reasons.

To see why, place yourself in the position of a judge who must consider what disposition he will select following the conviction of a sex offender. He first must decide whether the offender is amenable to treatment. If so, what treatment?

If only an inpatient program for incarcerated offenders is available, the judge will inevitably be tempted to send to the institution many offenders who need treatment but do *not* need incarceration—either for their own benefit or for the safety of society. As a result, the institutional treatment program will be increasingly filled with offenders who do not require its services. Since the cost of incarceration is very high, there will be a waste of public funds. Because it receives offenders who do not need incarceration, the program will have less room for offenders who do need it—and who will therefore serve their time in conventional institutions without treatment.

If the judge has only a community treatment program available, there will also be adverse consequences. He will inevitably be tempted to entrust to the community program offenders who need treatment but who also need isolation. This means taking risks with the community's safety which would not be taken if an institutional alternative were also available. Thus the community program will receive at least some offenders it is not adequately equipped to handle. Its effectiveness with those it is qualified to treat will be impaired. If some of the unsuitable offenders reoffend, the program's reputation will be damaged; indeed, a single widely publicized crime by a participant or alumnus may destroy a community program or seriously impair its effectiveness.

Having *both* an institutional inpatient program *and* a community outpatient program is also invaluable for continuing the treatment of incarcerated offenders following their release on parole. This issue too, is explored further in the Conclusions and Recommendations below.

D. Program For Juvenile Sex Offenders, Seattle

2.16. Juvenile Rapists and Child Molesters

When sex offenders begin to talk frankly in a treatment program, or when they write their autobiographies, their stories almost always begin with their adolescence, perhaps soon after puberty—or even earlier. Often their actual criminal offenses—the raping of girls or boys their own age, the sexual molestation of boys and girls much younger than themselves—began this early. Even where overt offenses came later, there may have been an early fantasizing of bizarre sex crimes and an inability to take part in the customary sociosexual learning processes in which their classmates and neighbors were involved. These autobiographical data make it clear that any program designed to curb the appearance of yet another cohort of adult sex offenders must begin at least as early as adolescence.

But little more than this can be said—for very little is directly known about juvenile sex offenders. The reminiscences of adult offenders are vague on some points, and consciously or unconsciously distorted on other points. Repeatedly, during site visits for this study, sensitive and dedicated therapists remarked, in effect: "If only we had had these men in their teens instead of in their 20's or 30's, we might have accomplished much more." Staff members in the adult programs visited were without exception enthusiastic when informed that the first program for

adolescent sex offenders was currently on the drawing boards at the University of Washington in Seattle.

Another very frequent feature in the autobiographical accounts of adult sex offenders is their early experiences as *victims*—their sexual abuse or exploitation by older adolescents or adults during their childhood. But here, too, the details, as recalled decades later, are of doubtful reliability, and the relation between the experience as juvenile victim and as adult offender remains vague. Studying juvenile sex offenders and sex offenses at the time of occurrence rather than decades later might turn up many clues to techniques of prevention.

To cite a simple example, almost every neighborhood has children who for one reason or another exclude themselves or are excluded from the ordinary sociosexual learning experiences of the neighborhood—the Boy Scout hayride, the junior high school dance, the birthday parties of classmates. By the time these excluded boys reach high school, what was originally a quite minor sociosexual handicap may have swollen out of all proportion—cutting them off from the socially acceptable modes of sexual acculturation enjoyed by their classmates and shaping precisely the kinds of sexual misfits who later turn up in sex offender treatment programs. Can intervention very early in this process of sociosexual exclusion—shortly after puberty or during adolescence, for example—alter the outcome? No one knows. No one has tried it.

In Seattle, these possibilities have been a concern of Dr. Robert W. Deisher, professor of pediatrics and director of the Adolescent Clinic at the University of Washington School of Medicine. The Adolescent Clinic provides psychiatric as well as medical diagnosis and treatment services, including referrals from the juvenile courts and from juvenile probation and parole services as well as from juvenile institutions. Thus Dr. Deisher gradually became aware that there are 15-year-old rapists, homosexual and heterosexual; 15-year-old molesters of 4-year-old children; 15-year-olds fixated on soiled female undergarments; 15-year-old exhibitionists and voyeurs—indeed, the whole range of socially condemned sexual behavior arising relatively early after puberty.

"I was recently asked to see a 16-year-old boy in a state juvenile institution," Dr. Deisher reports. "This boy had been there for approximately six months. He had been placed in the institution for rape or attempted rape of at least three girls in his neighborhood. After being placed in the correctional institution, on numerous occasions he had been apprehended molesting some of the younger boys within the institution. When confronted with this behavior, he says that he is not able to control himself and wants help with the problem."

Dr. Deisher also calls attention to cases outside the juvenile correctional system:

> A 13-year-old boy was referred to the University of Washington Adolescent Clinic because of learning problems and difficulty at school. He was significantly behind in his reading ability, did not like school, and was sometimes a behavior problem in school. After some discussion of these problems with the mother, she went on to tell us that she was even more concerned about another problem which she had never discussed with anyone. Although this problem had existed for over three years, and she was now hardly able to sleep at night for worrying about it, she had not been able to bring herself to talk to anyone about it. It began three years ago when the mother, who did some part-time babysitting to supplement the family income, found the boy on several occasions locked in the bathroom with younger girls, between 2 and 4 years of age. Frequently, he had undressed them and was bouncing them up and down on his lap in a sexually stimulating manner. She had spoken to him about this several times, but the behavior persisted and she had to keep an eye on him at all times. She did not tell the parents for fear of losing her business, but after she found that threats and talking to him did not stop the behavior, she gave up babysitting altogether. Within the past year, another type of disturbing behavior occurred. The boy had been burglarizing homes in the neighborhood, taking almost nothing except women's underclothing. He had hidden these undergarments in several hideouts in the neighborhood, as well as in his own room. The mother discovered that many of the undergarments had been burned and slashed and she has now reached the point of being concerned enough to want to talk with someone about it.

What happens to such young people *within* the juvenile correctional system? A young psychologist and a young sociologist, Toni F. Clark and William E. Henry, both employed within the Washington State correctional system, were given a three-month leave from their usual duties to find out. Their findings are no doubt equally applicable in many other states; indeed, few states have as effective a

juvenile correctional system as does Washington State.

In the first place, Clark and Henry found that the state's juvenile courts, in accordance with long-established principles which are sound in many cases, was relatively little concerned with the details of a child's offense. The commission of an offense was necessary to establish the court's jurisdiction; but once jurisdiction was established, the court was concerned with the "whole child" and with providing as effectively as possible for his or her future. In this process, the specifically sexual nature of the child's problem is likely to be diluted or soft-pedaled.

In the juvenile courts as in adult courts, moreover, a process of plea-barganing may occur. A child who has raped or molested three-year-olds may, on the face of the correctional system's records, be admitted for some lesser, usually non-sexual offense such as assault. Thus he moves on to a correctional institution, or to probation, with no indication of his sexual problems in his record.

Washington State maintains a fully staffed and equipped diagnostic center, known as Cascadia, for its juvenile offenders; but here too, Clark and Henry found, members of the staff—for the very best of motives—tended to soft-pedal and even keep out of the records altogether the specifically sexual nature of many offenses.

One reason for this was a very sound belief that early adolescence is a period of sexual exploration. One or a few deviant sexual acts shortly after puberty are exceedingly common in the life histories of the most respectable citizens as well as in the reminiscences of adult sex offenders. To make a mountain out of a molehill is not sound therapeutic practice.

Closely related was the quite proper concern in the juvenile courts and throughout the juvenile correctional system, in Washington State as elsewhere, that *labeling* a child as delinquent or deviant may have a profoundly adverse effect on his subsequent development. Neighbors steer clear of a child labeled as a sex offender, and keep their own children away from him. The school treats him differently. Thus he is further cut off from the sociosexual development of his cohort. The diagnostic staff is concerned that labeling a child as a sex offender may have equally adverse effects *within* the juvenile correctional system; it may affect the labeled child's relations with his juvenile parole worker, with the staffs of juvenile correctional institutions, and with other children in the institution. The label may also affect the child's perception of himself; he may try to live up to the label. The label thus becomes a self-fulfilling prophecy. The diagnostic staff in a juvenile correctional setting is naturally loath to institute such a cycle by labeling a child as a sex offender.

Finally, the staff at a diagnostic center quite properly asks, what good will labeling do? Neither the juvenile correctional institutions nor juvenile probation or parole workers are specially qualified to handle these sexually aberrant juveniles. There is no program anywhere in the juvenile system addressed specifically to their sexual problems.

The net effect, in Washington State as in most other juvenile correctional systems, is that youthful rapists, child molesters, and other sex offenders move through the courts, the diagnostic centers, the juvenile institutions, and the juvenile probation and parole systems with little or no attention paid to their specifically sexual problems—indeed, with little or no indication in their records that they *have* sexual problems.

One further factor may be cited. Many juvenile correctional systems are concerned with the specifically sexual misbehavior of *girls*— the "sexually promiscuous female adolescent." There is a substantial literature on this problem, and many juvenile correctional institutions for girls address themselves directly to sexual issues. But, perhaps as a reflection of the double sexual standard in adult society, there is sometimes a tolerant feeling that in the sexual sphere, "boys will be boys," and that intervention is unnecessary. The approach is clearly mistaken when applied to the cases cited above of 15-year-olds who repeatedly rape both girls and boys or who sexually molest children aged 2 to 4.

Alerted by his own experience and by the Clark-Henry report, Dr. Deisher in June 1975 called a day-long "Conference on the Male Juvenile with Sexual Offenses," sponsored jointly by the Washington State Office of Juvenile Rehabilitation and the University of Washington Adolescent Clinic. Those in attendance included representatives from the police, juvenile courts, juvenile probation, juvenile institutions, and juvenile parole services, as well as interested individuals from various helping professions. The purpose of the conference, Dr. Deisher notes, was "to discuss the current state of knowledge in the field and to begin to establish recommended priorities for activities to be conducted at each level in the system to change the way in which the system as a whole responds to young people with serious sexual problems."

At the conference, "the issue of labeling juveniles as sex offenders was discussed at length. It was recognized that inappropriate application of labels may lead to the establishment of sexual offender roles in individuals who have not developed, and who might not develop, self-concepts as sexual offenders. At the same time, it was recognized that without appropriate labels and descriptions of behavior, effective evaluation and treatment at the different system levels were not possible. Because of this, it was felt that the development of reliable evaluation criteria was imperative—both to protect juveniles from mislabeling, as well as to provide indications for the most appropriate treatment mode at the most appropriate level in the system for those who do have sexual problems."

Out of this conference, accordingly, arose a concrete proposal for launching the country's first program for the diagnosis *and treatment* of juvenile male sex offenders. The diagnostic portion of the program was promptly begun at the University of Washington Adolescent Clinic. When visited in the spring of 1976, however, a delay in funding was delaying the treatment portion of the program.

2.17. Need for a Juvenile Treatment Program

Two basic principles of the Washington State approach warrant emphasis here. From the beginning, Dr. Deisher and his associates saw the enormous importance of making treatment available *at all three levels of the juvenile correction system*—the probation level, the institutional level, and the parole level. This need is the precise parallel of the need, stressed repeatedly in this study, to have both institutional and community-based programs for adult sex offenders. If Washington State were to establish only a program for juvenile sex offenders domiciled in one of the state's juvenile correctional institutions, juvenile court judges would be under strong pressure to take out of their homes and schools and to lodge in that institution children who would be better off at home. Conversely, if only a program for children on probation or parole was established, children in need of treatment would almost certainly be left in their homes—even though they needed institutional care.

The second principle stressed in the Clark-Henry report and elsewhere in the Washington State plan is the need for education concerning human sexuality—and specifically adolescent sexuality—for staff members throughout the juvenile courts and juvenile correctional system. One goal is to make staff members better able to distinguish between adolescent sexual "horseplay" and symptoms of serious sexual problems. Another is to make staff members more comfortable with adolescent sexuality—so that they do not "freak out" when confronted with either minor or major examples of adolescent sexual behavior in a child's records.

A third goal of sex education for staff members might be making them comfortable with their own sexuality, and thus better able to discuss sexual matters comfortably with young people in their care.

At this writing (April 1977), the funding problems of the Adolescent Clinic treatment program have still not been resolved; but individual juveniles were already in treatment at the Adolescent Clinic. The national significance of this program—the first in the country to address itself to the specifically sexual problems of male juveniles committing serious sex offenses—can hardly be overestimated. Other states currently planning treatment programs for *adult* sex offenders should consider the simultaneous launching of at least modest programs for serious *juvenile* sex offenders in institutions and in the community.

E. The Albuquerque Program

2.18. Origins

Albuquerque's program for sex offenders arose out of a problem common to many cities and counties: the almost total absence of alternatives to imprisonment for nonviolent or "passive" sex offenders—such as exhibitionists, voyeurs, and child molesters who exhibit no violence in their offenses. Since no treatment programs were available in New Mexico's correctional institutions, imprisonment seemed a wasteful, fruitless, and perhaps counterproductive procedure for these offenders in urgent need of treatment. The problem surfaced when a psychiatrist at the Bernalillo County Mental Health Center interviewed twelve county judges concerning their sentencing problems. "The judges recognized that many such offenders were primarily in need of treatment rather than incarceration and that such treatment was either difficult to provide, or unobtainable, in a correctional setting." All twelve agreed that if a community treatment program were established for nonviolent sex offenders, they would make use of it in their sentencing determinations. They estimated that 90 percent of the offenders coming before them might be eligible for community treatment rather than imprisonment.

The program which subsequently arose was sponsored initially by the Bernalillo County Mental Health Center, and opened its doors in 1972. The program was at that time called PASO (Positive Approaches to Sex Offenders), and was financed by a three-year grant from the U.S. Law Enforcement Assistance Administration to the Mental Health Center. PASO's initial staff consisted of a psychiatric social worker—Wallace Crowe, M.S.W.—who served as both director and counselor, plus one secretary. During the next four years, under Wally Crowe's direction, the program expanded continuously and remodeled itself periodically in response to community needs.[7]

One early change was the moving of the program from the Mental Health Center—which many of the men in treatment felt to be an inappropriate setting—to a storefront building close to other community services. A second major change was the extension of PASO's services to rapists and other violent or aggressive offenders—most of whom entered the program after serving time in a state correctional institution or following release from a state mental hospital. Three-quarters of the clients are now aggressive offenders. The admission of these men to the program, in turn, focused attention on the need for treatment facilities within the state's institutions—and PASO periodically sent small teams into the institutions to conduct group therapy sessions and to assist in preparing release plans for men returning to the community. A counseling service for rape *victims* was also added to the program, plus counseling for the wives and families of offenders.

Upon expiration of the three-year LEAA grant, PASO was split off from the Mental Health Center and became temporarily an independent social agency financed by the City of Albuquerque. Shortly thereafter it was merged with other programs for ex-offenders and became the Sex Offender Treatment Program of Alternatives House, a community agency.

The expansion of services required, of course, an expansion of staff. Two full-time counselors were added. Additional staffing was made possible through the program's close association with the University of New Mexico; two candidates for the doctoral degree in guidance and counseling plus four candidates for the master's degree served on the staff part-time. One full-time and several part-time volunteers were also recruited. The majority of the staff is female—providing the offenders, perhaps for the first time in their lives, with an opportunity to establish significant relationships with adult women.

2.19. Goals

The Albuquerque program formally described its treatment objectives as follows:

- To help clients develop interpersonal social skills through group therapy
- To help clients develop strong conditioning against a repetition of offensive sexual behavior
- To help clients develop a compassionate concern with the welfare and interests of others
- To enable clients to express and handle their hostilities and resentments
- To present opportunities for growth and maturity in social responsibility
- To enable clients to enhance their self-image as mature adults
- To develop awareness that sexual behavior involves responsibilities as well as gratification.

In marked contrast to the Santa Clara County program, which focuses primarily on the incest offender in the context of his wife and children, the Albuquerque program serves primarily a youthful unmarried population (70 percent under 30 and 19 percent under 20; only one-third of clients are currently married). Thus major emphasis is placed on individual and group therapy—though marital and family counseling are available.

Essentially, for these young men cast loose in a city, the treatment program is *a place to take their problems before their problems overwhelm them*. Their feeling toward the program is molded in part by the fact that counselors are available when needed, without advance appointments—a rarity in social programs. "Fifteen minutes at a moment of crisis may be worth many hours of therapy when no need for help is felt," Wally Crowe explains.

In 1976, the Albuquerque sex offender program, along with the other programs for ex-offenders, joined together in Alternatives, Inc., has restructured its services in terms of a contract with each client. The contract, which may be either verbal or in writing, specifies the services which the program will provide—individual counseling, group therapy, marital or family counseling, job-training or placement, etc. It also specifies the length of time over which each service will be provided—and the client's responsibilities for making use of these services. The contract may be amended or extended by mutual agreement at any time. It may be terminated "at the completion of the contract, or when the client

[7] Wally Crowe resigned in the fall of 1976; the account which follows is limited to the period prior to his resignation.

voluntarily requests termination, or when the client fails, through negligence, to fulfill his/her part of the contract."

2.20. Strengths and Weaknesses

During its first four years of experience with several hundred sex offenders, only three serious crimes were reported among those involved in the program; all three were rapes. It was not only or primarily the community treatment program which failed in these cases, however. One of the rapists had spent five years in prison and another thirteen years before entering the Albuquerque program.

Currently the Albuquerque program is composed of two parts. One part, which provides an alternative to imprisonment for "passive offenders" in need of treatment rather than incarceration, is headed by Margot Berger. The other part is a program for "active offenders" following their release from imprisonment; it is headed by Judy Fleischman.

Essentially, the quality of the services rendered in the Albuquerque program, or in any other community program for sex offenders, depends primarily on the quality of the staff and its dedication to the program. On both of these points, the Albuquerque program appears to have earned high scores. Equally important, the program has played an important role in the entire structure of New Mexico's social responses to sex offenses.

At about the same time that Albuquerque's treatment program for sex offenders was launched, a treatment program for rape victims and a rape education program were also launched. The three programs, in Albuquerque as in South Florida, were seen as parts of a concerted community response to sex offenses. All three programs, in cooperation with other agencies, were instrumental in establishing the New Mexico Task Force on Sex Crimes, an agency which over a period of three years significantly altered the handling of sex offenses and victims throughout the state.

One achievement of the task force, for example, was the modernization of New Mexico's laws governing sex offenses—laws which dated from the days when New Mexico was still a territory rather than a state. State and local police and prosecution procedures were similarly modernized. There is even a suggestion that the program has had national repercussions; New Mexico Senator Pete V. Domenici, an active supporter of the task force, was cosponsor of the Federal law establishing a National Center for the Prevention and Control of Rape in the National Institute of Mental Health.

Communities concerned with developing a rational response to their local sex offense problems can thus learn a basic lesson from the Albuquerque experience. A program for the treatment of sex offenders is an essential and useful ingredient in the total response—along with such parallel efforts as reform in the sex offense laws, rape education, and services to rape victims.

PART III. FOUR OTHER INSTITUTIONAL PROGRAMS

3.1. The Norwalk Program (1948–1954)

Michigan was the first state to enact, in 1937, a "sexual psychopath" law; and similar laws were enacted thereafter in many other states:

Illinois, 1938
California, 1939
Minnesota, 1939
Vermont, 1943
Ohio, 1945
Massachusetts, 1947
Washington, 1947
Wisconsin, 1947
District of Columbia, 1948
Indiana, 1949
New Jersey, 1949

On their face, these sexual psychopath laws looked like liberal reform measures. They provided that persons found to be "sexual psychopaths," a term derived from Krafft-Ebing, should be provided with treatment in an effort to cure them of this dread disease. In fact, however, the state legislatures which passed these laws, often by very large majorities and with little or no debate, neglected thereafter to establish or fund any treatment programs. (Some have still not established a treatment program.) The two underlying purposes of these laws were nevertheless achieved at least in part:

First, a person could be locked up in a mental hospital following a finding that he was mentally ill without many of the constitutional safeguards—right to trial by jury, right to cross-examine witnesses, and so on—to which an accused person is entitled in a criminal trial. The sexual psychopath laws were first and foremost an effort to incarcerate persons accused of sex offenses as if they were mentally ill, without convicting them of a particular sex offense. Because the incarceration was (allegedly) for treatment rather than punishment, the constitutional safeguards of the criminal law were thought not to apply.

Second, most sexual psychopath laws provided no specific terms of imprisonment—or even minimum and maximum terms, such as one-to-ten-year sentences. Rather, a sexual psychopath could be kept locked up until treatment was successfully completed—that is, until he was found by a judge or review board to be no longer a danger to the community. If no such finding were made, offenders could be (and some were) kept locked up as sexual psychopaths until death terminated their incarceration. The likelihood that they could win release as "cured" was severely impaired, of course, by the fact that no treatment was in fact provided them during their incarceration.[1]

The constitutionality of these sexual psychopath laws was, of course, repeatedly challenged. Defense lawyers hammer away particularly at the Achilles' heel of the laws: locking offenders up for treatment yet failing to provide the treatment. Perhaps to avoid such a court challenge, California in 1948, nine years after the law was passed there, actually began providing treatment at its Metropolitan State Hospital in Norwalk, California.

The program at Norwalk lasted only six years, and it left behind few traces in the published or unpublished literature. Among its early visitors, however, were Dr. Alfred C. Kinsey and his closest associate, Dr. Wardell Pomeroy. Dr. Pomeroy's record of that visit constitutes perhaps the first account of a sex offender treatment program in the United States.

". . . Kinsey got a letter one day," Pomeroy later recalled, "inviting him to talk to the sexual psychopath patients there [at Metropolitan State Hospital], in return for which he would be able to get their histories. At the time there were about two hundred of these patients in the [hospital]. Kinsey saw the invitation as a special opportunity. We had interviewed only a few such people, and he was anxious to talk to more of them, and learn how they were different from other people."

In the course of the visit, all but one of the 200 sexual psychopaths voluntarily gave Drs. Kinsey and Pomeroy their sexual histories. Pomeroy was equally impressed, however, by the institution itself. "The whole situation seemed so unusual to me," he wrote in his biography of Kinsey, *Dr. Kinsey and the*

[1] While these sexual psychopath laws remain on the statute books in many states, they are rarely or never used in some states—and legal amendments or judicial decisions have tended to limit their harshness in some states where they are still used.

Institute for Sex Research (1972), "that I thought it worthwhile to make my own record of what happened there.

". . . California had passed a law governing sexual psychopaths which had simply resulted in taking these two hundred inmates bodily and transporting them to Norwalk, whose administration knew nothing about how to handle them, since this was a standard mental hospital which did not deal in such cases. Now they had two hundred prison inmates who had been transformed suddenly into hospital patients. These men were in custody for offenses covering a broad range of sexual behavior, including homosexuality, pedophilia, rape, incest, exhibitionism, and voyeurism. All of them had been convicted; all had been declared psychopaths."

Since the staff at Metropolitan State had no preconceived ideas of how sexual psychopaths should be treated, and no model developed elsewhere which they could follow, they had to innovate. Dr. Pomeroy listed seventeen innovations which impressed him particularly:

1. The men wore their own civilian clothing.
2. Wives and family members were allowed to visit the men in their quarters.
3. They were allowed to have privacy with their wives, but after one became pregnant this had to be stopped.
4. Previous patients who had been released were welcomed back to visit.
5. There was unlimited and uncensored correspondence.
6. Work assignments were based on the patient's need, not on what the institution might require. For example, an experienced plumber might be assigned to the kitchen detail on the ground that his homosexuality might be helped by contact with women kitchen workers, even though plumbers were badly needed.
7. There was freedom of movement among the group, and they were even permitted to go into the town of Norwalk under certain controlled conditions. At the beginning there were several escapes, but when the patients returned they were ostracized by the others, and this kind of social pressure ended the escapes.
8. Patients were allowed to have unlimited cash in their pockets.
9. Unlimited gambling was permitted. The administration reported that the professional gamblers among the men quickly won all the others' money, then gave it back so the game could go on.
10. Patients were free to have any pictures they wanted. One large calendar picture hanging in the dining room was the famed nude photograph of Marilyn Monroe. Suppression, said the hospital, would have been worse, and so homosexuality was not suppressed either.
11. Young children came on visiting days, because it was believed that pedophiles must learn to live with them without danger. There were no incidents.
12. A group of Norwalk housewives, known as the Bib and Apron Club, asked if they could help and were told they could come in once a week and give a dance, so that patients could be taught how to observe the amenities. These occasions would also give them a connection with the outside world.
13. Inmates had the privilege of "firing" any guard or officer they did not like. These people would simply be transferred elsewhere in the hospital.
14. Women therapists were part of the staff.
15. The entire program was therapy oriented, and went on twenty-four hours a day. Formal therapy was developed in what was called the "doctors' group." Eight to ten patients spent about two hours a week in the group with a therapist.
16. There was also a patients' group. No trained therapist sat with these patients, but certain patients from the doctors' group were assigned to it.
17. Inmates often proved to be better judges than the therapists of whether a particular inmate was going to adjust well in the outside world.

"Under the program I have just outlined," Dr. Pomeroy added, "there was about a 5 percent return rate after the men were released, in contrast to a 20 to 50 percent return in other groups.

"One would think that this sensible situation would have been not only encouraged but broadened in the state penal system. Instead California built a $20 million institution [Atascadero State Hospital] to which all sexual psychopaths were sent, and the Norwalk program was ended. The new institution had no such spark, and although some feeble, halfhearted attempts were made to copy the original idea, it was never as successful.

"Ironically, the administration at Norwalk had no realization of what a remarkable thing it had done. Its members were not aware that they had been innovators, and that other hospitals treated these patients quite differently. Since that was true, the

Norwalk story was never told in its entirety, but I believe it still stands today as a model for treating those whose sexual behavior has been condemned by law."

3.2. The Atascadero Program

The institution to which the Norwalk patients were transferred in June 1954, Atascadero State Hospital in Atascadero, California, was a hybrid institution—part maximum security prison and part mental hospital—located in the middle of the state, remote from both northern and southern centers of population. It had a capacity of 1,200—much too big for maximum therapeutic effectiveness. In addition to sexual psychopaths—renamed "mentally disordered sex offenders" or MDSO's when the sexual psychopath law was amended—Atascadero contained a number of groups known as the "criminally insane": persons unable to stand trial by reason of insanity, persons found not guilty by reason of insanity, psychotic patients transferred from the correctional system, and others deemed a menace to society, in need of maximum security precautions. About half of the Atascadero population is commonly composed of MDSO's.

An informal history of the institution, distributed in 1975, reports that Atascadero opened "with the philosophy that good therapy could be carried on in a security setting and that modern methods of psychiatric treatment, based on a 'therapeutic community' concept, would most likely succeed.

"The problems of 'therapy vs. security' and 'prison vs. hospital' immediately developed and hindered successful treatment. The belief that criminals should be punished for their crime and not 'babied' haunted the hospital program. For several years beginning in 1959, a series of unfortunate and tragic accidents occurred at the hospital. A number of escapes and violent incidents in addition to widespread community concern led to a special investigation of the hospital's problems which ultimately resulted in a revamping of its organization, administration, and treatment programs" beginning in 1961.

The 1960's were also a troubled decade for Atascadero, plagued by internal dissension, staff rebellions, and occasional scandal; the details are irrelevant to this study. Our primary concern is with a three-year period beginning in 1972, when Atascadero was briefly the site for a number of innovative treatment approaches which warrant full consideration.

The innovative features stemmed from a 1971 "Hospital Improvement Grant" (HIP) from the National Institute of Mental Health to Atascadero State Hospital—one of the few such grants in the history of sex offender treatment programs. Dr. Michael Serber, a psychiatrist, was the project director for the grant; and he drew freely on the Resnik-Wolfgang essay, "New Directions in Treatment" (see page 7) when developing the new Atascadero program.

Almost immediately, however, dissension arose between Dr. Serber and his newly recruited staff on the one hand, and Atascadero's director and his senior staff on the other.

"The HIP Project met with so much resistance and hostility from the hospital administration," a staff member subsequently wrote, "that at one time every employee hired with grant funding, including Dr. Michael Serber, the project director, was dismissed and an attempt was made . . . to return all funds to NIMH. Naturally, this was seen as a rather unusual request, there being no ready mechanism to accept returned funds in the middle of the year. There was some delay along with investigations into treatment and forensic abuses at the hospital. As a result of these official inquiries, the HIP grant and its personnel were reinstated and the entire hospital was soon [1972] to begin the task of a total reorganization into treatment programs designed and geared to meet the needs of its patients."

Pursuant to this 1972 reorganization, ten treatment units were established—of which the "sexual reorientation program" was of particular interest. This was the joint responsibility of Dr. Serber himself and a woman associate, Ms. Claudia G. Keith; it was concerned with the approximately 180 homosexuals held at Atascadero—most of them for offenses involving male partners or victims under the age of 18.

"The history of treatment for the homosexual at this institution," Dr. Serber wrote, "has mainly centered around inadequate and sometimes cruel attempts at conversion to heterosexuality or asexuality. There is an intermittent history of aversive conditioning. These aversive techniques had extended even to the use of succinylcholine and electroconvulsive shock treatment as punishment for homosexual offenders who had 'deviated' within the hospital. At the very minimum, homosexuals were frequently degraded by staff whose attitudes concerning homosexuality were punitive and judgmental. More homosexual patients than heterosexual had been defined as unamenable to treatment after a period of hospitalization and then were sent to prison

via the courts under the ambiguous judicial system that determines the fate of sexual offenders in the state of California." One important facet of the new program, accordingly, was to provide for "the desensitization and education of staff members in relating to homosexuals."

In lieu of the old goal of converting homosexuals into heterosexuals or suppressing their sexuality altogether, the expectation of the Serber-Keith program was that "*patients would attain adequate knowledge and skills necessary to return to their communities, keep out of trouble with the law, and not molest young boys.*"

Viewed from this point of view, most of Atascadero's homosexual offenders were seen to resemble quite closely most heterosexual offenders; "generally, these patients lack the basic verbal and nonverbal skills necessary to successfully interact with others. Often they feel so inferior with people their own age that they prefer the company of children or juveniles." This theme of *inferiority feelings* as a barrier to mature sexual functioning is common to almost all treatment programs. "In addition, most homosexuals in this hospital have no knowledge of what social alternatives are available to them in the community or with what groups they might identify or enlist for support upon release from the hospital."

To implement the goals, Ms. Keith reports, she and Dr. Serber secured "gay student volunteers from a local college campus who are successfully integrated into straight society and who functioned as instructors and behavior models."

Role playing was the first mode of therapy tried—much as role-playing was used in another part of Atascadero to teach heterosexual social skills. "The scene used was that of a gay bar where social contacts are frequently made." The men learned how to enter such a bar, how to establish eye contact, how to start a conversation, and so on. Later a living-room scene was substituted for the bar; homosexuals complained that use of a bar scene perpetuated an unfair stereotype.

Another facet of the program was the launching of a consciousness-raising (CR) group, modeled after the CR groups found in the women's movement. "A gay, female paraprofessional with experience running consciousness-raising groups [for women on the outside] was asked to assume leadership of 10 extended group sessions." As in women's CR groups, the emphasis in this gay group was on emotion-laden problems which are rarely confronted from a rational point of view. "Certain subjects were repeatedly and extensively discussed. They were: (a) the problems of being gay in a predominantly straight society; (b) the means of dealing with family members in relation to the group member's homosexuality; (c) difficulties in finding work, keeping it, and associating with employer and fellow employees; (d) social alternatives for homosexuals; (e) association with straight friends; and (f) the situations to be avoided in order not to be subsequently rearrested." The CR sessions also familiarized each participant with "the gay organizations that will be open to him when he is released and how these organizations can provide social, professional, and therapeutic support."

Quite early in the program, Ms. Keith states, several advantages became visible. "Some patients have learned new skills and feel more knowledgeable and self-confident in both gay and straight settings." Opponents of the new program had feared that it would lead to increased homosexual activity within the institution; but "no increase in sexual acting out has been reported by group members or nongroup members throughout the institution. The homosexual patients, on their own initiative, are in the process of forming a club within the hospital that will serve as a self-help organization and a community liaison service. . . . We have demonstrated in a very short time significant advantages to both patients and staff. Follow-up may well reveal advantages to the community as well."

In addition to the program for homosexuals, Ms. Keith reports, "a sexual preference group was organized . . . in order to help patients who are unsure of their sexual orientation. An attempt is made to aid the patient in determining whether his interests lie with homosexuality, heterosexuality, or bisexuality. Although not specificially a part of the homosexual treatment program, this group has been an important adjunct to the treatment of many patients."

Ms. Keith added, however: "Despite our successes, we have and are experiencing many problems and, like any conscientious treatment program, we are constantly in a state of evolution. Perhaps the most frustrating realization which we have had to make is that the homosexual treatment program does not offer the golden solution to the treatment of male child molesters as we had once hoped A major problem which we as yet are not effectively treating is that these patients are really turned on by male children for various reasons and many actually prefer them. We currently must rely on other aspects of the Sexual Reorientation Program to aid the patient in developing the necessary self control to choose the

behavioral alternatives provided by the homosexual treatment program instead of child molestation."

Half a dozen other innovative features can be more briefly described:

Family Interactions Skills Program. Under the direction of Dr. Robert E. Hiller, a psychologist, this program sought to involve the wives and families of offenders in their treatment. Family therapy proved of great value despite two shortcomings: lack of adequate professional staff and the hundreds of miles many families had to travel to reach Atascadero.

Aggressive Behavior Management Program. This program from 1972 to 1975 was under the direction of Dr. Paul Bramwell. "A small segment of the [Atascadero] patient population," Dr. Bramwell noted, "exhibits uncontrolled aggression which constitutes a danger to themselves and to others and which also seriously impedes therapy for the patient's more basic problems." His project he described as "a specialized and intensive treatment program which is designed to control and modify that behavior."

Assertive Skills Training Program. Under the direction of William Ernst, this program was designed to "provide patients with additional methods of emotional expression and problem-solving skills which will lead to more behavioral options in regard to making and keeping friends, finding employment, and solving other problems inherent in daily living."

Interpersonal Communications Skills Program. Under the direction of Dr. Alan S. Goodman, this program was designed to serve Atascadero residents "with gross deficiencies in effective methods of communicating thoughts and feelings to others and those that are inarticulate, passive, dependent, or incapable of assessing the communications of others."

Community Planning, Orientation, and Transfer Program. This program, headed by Diane Serber, was designed to help bridge the gap between institution and community for those about to be released and for those already out. Once again, remoteness of the institution from the centers of population served made release planning and aftercare exceedingly difficult.

Sex Education. A major facet of Atascadero during its "golden age" from 1972 to 1975 was a sex education program under the direction of Paul Burkhardt. This program, like several others, made use of sex education films developed by the Multi-Media Resource Center in San Francisco for educational use; in addition, the NIMH grant funded three films made specifically for sex offenders. Sexual physiology was taught; but more stress was placed on sexual psychology. "We feel that any successful, intimate sexual relationship is based on the attitudes of the partners," Mr. Burkhardt wrote. "Too many times patients who have sexual difficulties find that they and their partners have entirely different expectations of each other. This course is designed to teach people how to enjoy a sexual relationship and each other by reaching a common understanding of each other's needs and expectations." Areas covered included the history of sex, the nature of human sexual responses, male and female, "pleasuring" (foreplay), oral-genital sex, sexual intercourse, postcoital responses, and such sexual dysfunctions as absence of female orgasm, problems of male erection, and premature ejaculation. To minimize the difficulty of teaching such a course in an all-male institution, women staff members were used as teachers and counsellors to the extent possible.

An unhappy ending. In 1975, the NIMH grant for the funding of innovative treatment approaches at Atascadero expired and was not renewed. Dr. Serber, the clinical director primarily responsible for the innovations launched in 1972, had died and no successor had taken his place. By the spring of 1976, a number of the others associated with the 1972–1975 innovations—Bramwell, Goodman, Hiller, Keith, Ernst—had left Atascadero and their programs were discontinued. The sex education program under Paul Burkhardt, Diane Serber's aftercare program, and a small-scale research program under Dr. Richard Laws still functioned;[2] but little else was visible which was addressed specifically to the *sexual* problems of sex offenders. Note: An additional California program was launched at the Patton State Hospital in Patton, California, in the Spring of 1976. It is described in Appendix A, p. 76.

3.3. The Adult Diagnostic and Treatment Center, Avenel, New Jersey (formerly the Rahway Treatment Unit, Rahway State Prison)

Prior to 1963, sex offenders sentenced under New Jersey's sexual psychopath law were deemed mentally ill and were incarcerated in secure units in the state's mental hospitals. As in most other states, these hospitals provided no special treatment program for sex offenders. In 1963, however, a state-

[2] Since this was written, Atascadero's Sexual Behavior Laboratory under Dr. Laws has been expanded into a treatment as well as research facility. See Bibliography.

wide scandal involving several state hospitals resulted in widespread community protests—and in the gradual transfer of sex offenders from the state hospitals to the maximum security prison at Rahway, New Jersey.

The Rahway State Prison officials did not want the sex offenders—and neither did the state's Division of Correction and Parole. A compromise was accordingly arranged which may be of interest to other states planning sex offender treatment programs.

In brief, a separate building within the walls of the Rahway State Prison was set aside for the sex offenders. Treatment was placed under the jurisdiction of the Division of Mental Health, while the prison maintained security. Offenders lodged in the treatment unit left the unit for meals and for work assignments elsewhere in the prison; but in other respects the sex offender unit was an independent enclave within the prison.

In 1967 a psychologist, William E. Prendergast, Jr., became director of the Rahway Treatment Unit; and during the next nine years, he made it one of the best-known treatment programs for sex offenders in the country. One result was that New Jersey voters in a statewide referendum passed a bond issue for the construction of a new building specifically for the sex offender treatment program; the building, which is in Avenel, New Jersey, but is only a few hundred yards from the Rahway State Prison, received the sex offender population from the prison in February 1976. It is the only structure in the country built specifically for a sex offender treatment program.

Curiously enough, the physical move from the prison to an independent site in 1976 was accompanied by a reverse bureaucratic move; jurisdiction was transferred from the Division of Mental Health and Hospitals to the Division of Correction and Parole. Simultaneously, the institution was renamed the Adult Diagnostic and Treatment Center and Dr. Ira Mintz, a clinical psychologist, was named superindendent. The Center now has two units—a diagnostic unit for service to the courts and the correctional system, and a treatment unit. Bill Prendergast remains on as Director of Professional Services in the treatment unit.

As director of the program from 1967 to 1976, Bill Prendergast developed a very personal theory about sex offenders, and a very personal mode of therapy growing out of that theory. Like other therapists working with sex offenders, Prendergast noted that in a remarkable proportion of cases the sex offender had himself in childhood been the *victim* of one or more sex offenses. Prendergast concluded that the childhood experience as a victim underlay the subsequent compulsive behavior as a sex offender. Further, he believes that many offenders who deny having been sexually molested as children have had similar experiences but have forgotten them. Out of these beliefs arose a treatment approach which Prendergast labeled ROARE (Reeducation of Attitudes and Repressed Emotions).

During a ROARE therapy session, offenders are given the opportunity to "regress" to an early age; in the course of the regression they often report uncovering a traumatic sexual assault upon themselves at an early age—and they relive that experience, often with deep or even violent emotional accompaniment. The procedure resembles the "abreaction" in traditional Freudian therapy. The ROARE approach also includes various methods of helping the offender to assimilate this newly unearthed experience and to restructure his future attitudes—presumably in ways which do not include compulsive sexual offenses. The ROARE experience is an emotionally very moving one—which some observers have likened to a religious "conversion" experience.

Evaluating either the ROARE theory or the ROARE experience is hardly possible, however, on the basis of the data available—though numerous observers agree that it has produced remarkable effects in selected cases. Several other Prendergast innovations may be of more general interest to other programs and to those planning future programs.

One is the intensive and innovative use of closed-circuit television. Not only ROARE therapy experiences but a variety of other therapeutic procedures are routinely videotaped in a studio excellently equipped for the purpose. The videotape circuit is wired through Prendergast's office so that he can monitor therapeutic sessions anywhere in the building. Material of interest from any videotape can be transcribed onto a master tape for future reference or for training purposes. A participant in a ROARE session is expected to play back the tape for his own information within a day or two, so that he can "see himself as others see him." A number of human growth centers outside of the correctional system have found this use of videotape playbacks of very great value in putting participants in touch with their own feelings and with the image they project; the New Jersey experience indicates that the videotape playback can similarly be of very great value in a treatment program for sex offenders.

A second Prendergast principle is the emphasis on vocational training for sex offenders—on the theory

that a man skilled in a job he enjoys is less likely to reoffend. By far the most successful vocational training approach has been the training of sex offenders in the use and maintenance of the audiovisual equipment. Indeed, during the move from Rahway State Prison to the new center in Avenel, offenders handled the installation and very complex wiring of all equipment, and currently operate the equipment in accordance with sound professional standards. Alumni of the training are fully qualified as audiovisual technicians. The possibility of introducing other innovative forms of vocational training within a treatment program should be considered by other programs.

Further, the program at Rahway and now at Avenel places major emphasis on "patient-directed responsibility," or PDR. A PDR program participant decides for himself the form which a therapy session shall take, what other participants or staff members he wants present, and so on. On some occasions, he may choose to be alone in the studio, engaging in a soliloquy or "acting out" his feelings—for subsequent replay by himself and his therapist. On other occasions he may prefer a session with a single therapist, or with a fellow participant or two, or with his entire group. He may also specify what roles he wishes the others to play—whether they should confront him, or provide emotional support, or remain passive and silent.

Finally, the Avenel schedule includes a number of "paraprofessional groups" under the leadership of individual sex offenders. At an appropriate stage in his own therapy, any offender may submit a proposal for such a group, to be held under his leadership under the supervision of a professional staff member. The proposal specifies the subject matter to be covered and the approach to be used. One offender concerned with alcohol problems, for example, leads a group on alcoholism. Another leads a "KEY" group aimed at "*K*nowledge through *E*xploring *Y*ourself." A third leads a group concerned specially with the problems of recidivists and parole violators. Sessions are tape-recorded, and may be played back during training sessions for the group leaders. One obvious effect of these "paraprofessional groups" is that the total program is enriched beyond the available time of staff therapists. A second advantage is increased program relevance; the paraprofessional groups which survive are those which strike a responsive chord in other offenders, and the participants in each group are those in whom that chord has been struck. Note: Two other programs operated in state correctional institutions are described in Appendix A: **The Program at the Trenton State Hospital (page 80)**, and the **Program at the Colorado State Reformatory** (page 79).

3.4. Minnesota Security Hospital (St. Peter) Programs

The Minnesota Security Hospital has been the site of two quite distinct treatment programs for sex offenders, and a third was in the planning stage during the fall of 1976.

The first experimental program, known as BEAD (Behavioral, Emotional, and Attitudinal Development), treated fifteen sex offenders between April and November 1974, and a second group of fourteen between August 1974 and May 1975. Some of the twenty-nine participants were offenders serving time in the Minnesota State Prison who were transferred to the Minnesota Security Hospital for the BEAD program; others were already in the custody of the hospital. BEAD was funded by a grant from the Bush Foundation, a private philanthropy with headquarters in St. Paul. Dr. H. L. P. Resnik, whose innovative suggestions for the treatment of sex offenders have been described above (pages 8–9) was called in to advise the foundation; and in this way a number of his suggestions found their way into the BEAD program.

Like the programs at Fort Steilacoom, South Florida, and elsewhere, the BEAD program was built around intensive group therapy sessions involving every aspect of the offenders' lives; but there were differences at BEAD. In addition to the fifteen offenders in residence, five young women from the nearby St. Peter community participated in the group sessions. These "co-participants" were volunteers "recruited on the basis of their maturity, emotional stability, and sensitivity." Individual therapy was also a feature of the program.

Buttressing the therapy sessions was an intensive sex education program under the direction of Richard Seeley. Ten other women and men from the community participated in the sex education sessions along with the 15 sex offenders and the five young women volunteers; several of these additional volunteers were teachers or volunteers already involved in the hospital's general education activities.

The sex education sessions included many films, filmstrips, slides, recordings, and other audiovisual aids—some of them containing sexually explicit materials of the kind commonly used in college and medical school human sexuality courses. The two basic purposes of this educational approach, Dick

Seeley explains, were (1) "to obtain and discuss accurate sex information under proper education auspices," and (2) "to inquire into and clarify attitudes about a wide variety of human sexual feelings and behaviors." Simple exercises of the kind used in behavior therapy and Gestalt therapy were introduced "to assist participants in comprehending and appreciating their feelings and the quality of their interpersonal relationships." The presence of women and men from the community, of course, vastly enriched this concern with interpersonal relationships.

The large group of 25 or 30 split from time to time into smaller groups of six or seven "to facilitate greater freedom of expression. Topics dealt with included "ethical questions, interpersonal affectional relationships, the distinction between fantasy and behavior, and the mutual responsibility that sexual partners have toward one another."

The climax of the BEAD sex education program was the holding of a SAR or "sex attitude reassessment." (The SAR approach to sex education was pioneered at the National Sex Forum in San Francisco and spread from there to a number of universities and medical schools, including the Human Sexuality Unit at the University of Minnesota Medical School.) Each BEAD group was transported, under security precautions, to the University for its SAR. Some wives and close friends of offenders also participated, along with outsiders from the community. Essentially, a SAR is a "marathon" experience; for two days and one evening participants were continuously exposed to sexual audiovisual materials, descriptions of sexual behavior, and small-group discussions of the materials presented.

An evaluation of the BEAD program was made by Dr. Resnik, who pointed out many shortcomings and difficulties. Some of the sex offenders participating in BEAD were clearly unsuited for this kind of program. The BEAD staff was wholly inexperienced in the treatment of incarcerated sex offenders. Frictions and communication problems arose between the BEAD staff and the staff of the hospital. Responsibility was fragmented among the BEAD staff, the hospital staff, the Department of Public Welfare, the Department of Corrections, and the Minnesota Correction Authority which alone had power to parole offenders held in the correctional system. There were no provisions for aftercare following BEAD. Shortages of trained and experienced personnel compounded these difficulties. Stated differently, BEAD had bitten off more than it could chew with available staff and time span (the duration of the grant was 18 months). Too little time was available for advance planning and the laying of firm foundations. As a result, BEAD became an episode in the lives of its participants rather than a concerted correctional program for the identification, treatment, evaluation, release, and aftercare of sex offenders. These shortcomings are not here described as criticisms of either BEAD or of its dedicated and innovative staff—but as a warning to future programs to establish firm foundations, start slowly, and secure in advance the cooperation of all the other components in both the correctional and mental health systems.

In May 1975, following termination of the second BEAD group, a rather different Sex Offender Unit was established at the Minnesota Security Hospital. It is under the direction of Richard Seely, who had participated in the BEAD program and who had also visited the Fort Steilacoom program. In considerable part, the program Seely is currently developing is based on the Fort Steilacoom precedent—plus a major emphasis on sex education in accordance with the BEAD model.

The focus of the present program, Seely reports, is "to help residents develop self-help skills and the milieu within which personal problems are dealt with in an open, honest, and supportive way. Mandatory group therapy sessions are held 14 hours per week. Crisis intervention therapy is available on a need basis. Small task-oriented groups, team meetings, ad hoc committee meetings, and staff-council sessions provide ongoing therapy and staff contact on a 24-hour-a-day basis. . . . The therapeutic community concept provides a continuous therapeutic milieu." Volunteers from outside the institution, including women volunteers, participate in many activities.

The program's ultimate aim, Seely adds, "is the protection of society. It hopes to develop within the offender a new sense of pride in being able to recognize and control his deviant impulses and to govern his relationships with other human beings by concern for their feelings and rights. The program is based on the premise that this growth process can be achieved only in an environment providing opportunities and choices similar to community living. Basic components are respect and concern for the offender as a human being, close daily observation, confrontation, and psychotherapy—with privileges based solely on behavioral performance. All residents are expected to become completely involved in the treatment process. Any elopement, contraband, physical assaultiveness, or sexual misconduct constitutes a violation of the resident's contract and may

result in immediate transfer out of the Sex Offender Unit."

Further changes in the Minnesota program may lie ahead. In July 1976, as noted above (page 45), the Minnesota legislature ordered a study of the subject to be made, with recommendations for action. The study is being funded by the U.S. Law Enforcement Assistance Administration. Discussion groups throughout the state have considered the issue of treatment programs for sex offenders, and there has been widespread involvement of both state officials and private citizens. A foundation has thus been laid for a statewide approach to sex offender treatment programs going considerably beyond both the BEAD and the current Minnesota Security Hospital approaches.

PART IV. FIVE OTHER COMMUNITY-BASED PROGRAMS

Three of the sections below—section 4.1 on individual court arrangements, section 4.3 on castration and reversible chemical castration and section 4.5 on behavior modification—are concerned with general principles rather than specific programs. The remaining sections describe five innovative community-based treatment programs. (Five additional community-based programs are described in the appendices.)

4.1. Individual Court Arrangements

Long before the pioneer sex offender treatment programs were established in California and other states, a limited number of selected sex offenders received outpatient treatment rather than incarceration as a result of individual court arrangements. Such arrangements are still available in many, perhaps most, jurisdictions.

A typical case concerns a respected corporation vice president, aged 50, with no prior criminal record, who is arrested on a charge of child molestation. His first step, of course, is to retain counsel—an eminent local attorney familiar with the local courts and psychiatrists. The attorney's first step, in turn, is to retain as a consultant an eminent local psychiatrist well-known to the local judges; indeed, he may be the same psychiatrist whom the local judges themselves consult when faced with a difficult sex-offender case. Sometimes the psychiatrist who plays this role, both for the courts and on behalf of individual defendants, is a professor of psychiatry at the local medical school—a man whose specialty is forensic psychiatry.

The psychiatrist in such a case will thoroughly examine the defendant, take a psychiatric and sexual history, make a diagnosis, and submit to the defense attorney, to the court, or to both a detailed report—including a proposal for outpatient treatment. The psychiatrist may also agree to provide the prescribed treatment himself.

In a high proportion of such cases, the prosecuting attorney will agree with the defense attorney to recommend probation rather than incarceration following a plea of guilty to the offense charged or to a lesser offense—with treatment on an outpatient basis specified as a condition of probation. A judge is very likely to accept such a joint recommendation.

No study has ever been made of these individual court arrangements. No one knows how frequent they are, or the ultimate outcome. The psychiatrists who handle substantial numbers of such cases no doubt learn from their own experience, and from the experience of other psychiatrists, which cases can be safely handled on an outpatient basis in this way and which cannot. Every psychiatrist is keenly aware of the hazard he runs that one of his patients may commit a community-shocking, headline-engendering offense and that the psychiatrist himself may be blamed. He is therefore careful to accept for treatment only those patients whose likelihood of reoffending is acceptably low.

More research is clearly called for in this area of private court arrangements. Even in the absence of such research, however, no good reason appears why such arrangements should be curtailed. On the contrary, a substantial *expansion* of such arrangements appears warranted. In many jurisdictions today, the benefits of individual court arrangements are available only to well-to-do defendents who can afford high-quality legal representation and private psychiatric fees for both examination and treatment. The sons of well-to-do fathers may similarly benefit. The obvious need is to make similar arrangements available for otherwise qualified defendants who cannot afford to pay for such services out of their own pockets.

A number of the community treatment programs for sex offenders described below accomplish precisely this. They accept court referrals for diagnosis, make recommendations to the courts, and provide treatment on an outpatient basis for sex offenders who could not otherwise afford these services. Examples are the Philadelphia program described below, and the University of Maryland, University of Southern California, and Denver programs described in Appendix A.[1]

[1] A new program at the Fairview Southdale Hospital in Edina, Minnesota, a suburb of Minneapolis, was launched too late for inclusion in this survey but is listed in Appendix C. It is the only program sponsored by a voluntary general hospital.

4.2. Center for Rape Concern, Philadelphia

Of the outpatient treatment programs described in this study, this program at Philadelphia General Hospital is by far the oldest and best-documented. It has passed through three distinct phases, separately described below.

Phase I was launched in 1955 by a psychoanalyst, the late Dr. Joseph J. Peters,[2] with little community support at first beyond his own professional interest in trying out psychoanalytically oriented group therapy with sex offenders. He found in the greater Philadelphia psychiatric community several other fully qualified psychiatrists who were willing to devote one evening a week to sex offenders, without payment, in return for further training in psychoanalytic principles and in the practice of group therapy.

Securing sex offenders for the program proved more difficult. A major feature of probation for many decades has been the principle that offenders must not associate or congregate together. Indeed, this was an explicit condition of probation—and still is in many jurisdictions. A bank robber found conversing with two other bank robbers may have his probation revoked. Judges approached with a request that they refer sex offenders to the Peters program back in 1955 replied that the program itself was illegal; "group meetings would require criminals to congregate. The judges initially offered the greatest objections to and questions about the outcome of arranging meetings for homosexuals and drug addicts. They envisioned exchange of deviant partners and sale of drugs in court-sponsored group programs." A judicial distrust of psychoanalysis may have reinforced this strictly legal objection.

Dr. Peters' response was to meet periodically with the judges and with the court administrator to discuss *other* problems of mutual interest. As a result, he learned more about judges and the judges learned more about him; "what to do for the offender could then be discussed in an atmosphere of mutual trust by the courts and the clinic." This approach is strongly recommended to the directors of other treatment programs; for close cooperation between the courts and a treatment program is essential to program effectiveness.

The procedure agreed upon was simple. Judges were currently placing many sex offenders on probation—which meant that an offender had to meet with a probation officer once a month, review his life situation, and follow the probation officer's recommendations. This procedure was continued; but in addition, selected offenders who appeared to be in need of therapy were required as a condition of probation to attend at least 16 group therapy sessions at the Philadelphia General Hospital. A probation officer was assigned to the program to check attendance, to provide liaison between the program and the probation department, and to be helpful in other ways. Thus, in effect, the Philadelphia program offered to sex offenders generally the service previously available only to well-to-do offenders.

During the next ten years, some 1,600 sex offenders received group therapy at Philadelphia General Hospital. As the program grew, the city began paying for the psychiatric services which had initially been volunteered. At first the offenders were divided into three groups: child molesters, exhibitionists, and homosexuals. (Homosexual acts and homosexual solicitations in those days frequently led to criminal convictions; indeed, the homosexual group was the largest.) A fourth group was composed of miscellaneous sex offenders. In 1966 a fifth group, for rapists, was added. Dr. Peters believed that a group composed solely of child molesters, or rapists, or offenders sharing some other offense in common, could function more effectively than a mixed group; this is not the belief of most other treatment programs.

Each group contained from 12 to 15 members at any given time; it met once a week for an hour and a half, and it was open-ended—that is, as one offender completed the program or dropped out, a newcomer was added. Absenteeism reduced the actual attendance each week to eight or ten participants—some newcomers, some approaching termination of therapy, and some intermediate.

The Philadelphia experience was subsequently summed up in a series of papers (see Bibliography) by Dr. Peters, Dr. H. L. P. Resnik, Dr. Robert L. Sadoff, Dr. Joseph Steg, Dr. James J. McKenna, Jr., Dr. James M. Pedigo, and Hermann A. Roether—all therapists associated with the program. "During the first ten years," one report in this series notes, "sex offenders deny involvement in the act for which they have been arrested and convicted. Pedophiles (child molesters) are most vocal in their denial; they object in a direct, verbal barrage. On the other hand, the exhibitionists express their denial by passive-aggressive behavior such as absenteeism, silence, and withdrawal during the session."

Many offenders are unwilling to discuss the circumstances of their offenses at all initially; the few who do speak up "describe themselves as victims of

[2] Dr. Peters died in November 1976; Ms. Linda Meyer is now acting director.

other people such as wife, neighbors, and police." A few admit their offense—but insist that their problem has already been completely solved merely by arrest and conviction. "It won't ever happen again." Other new members agree with these denials, citing examples from their own histories—and that is where involvement in the group process begins. The new men, in the course of supporting one another's denials, become functioning members of the group.

Some offenders, the Philadelphia therapists found, never pass this initial phase and terminate treatment with little progress. But many progress to the middle phase, with more verbal participation in the group and more interactions with other group members. "There is less denial of involvement in the offense and less time is spent expressing hostility toward authority. As peer identification increases, the defenses of detachment, social isolation and passive-aggressive behavior decrease. Some middle-phase members challenge the denials of initial-phase members by stressing their own similar denials when new to the group. Absenteeism drops."

Some middle-phase members begin to "assert independent leadership. They start the session. They interview new members. They assume the role of therapist instead of following blindly a code of loyalty to fellow offenders. This small core of active individuals moves the [rest of the] group beyond the initial stage of denial, projection, and rationalization." Therapeutic attitudes are promulgated through members of the group rather than on the authority of the therapist.

Some group members gain relatively deep insights into their own motivation, Dr. Peters and Dr. Resnik continue. A pedophile, for example, may begin by blaming his offense on his wife's rejection. Later he may realize that his unconscious fear of women has kept him from establishing a satisfactory relationship at home—and he may further realize that it is his feelings of masculine inadequacy which makes him approach little girls rather than adult women; little girls "make fewer demands at the emotional level and are less likely to reject him." Such deeper factors, when unearthed, come as revelations to the other group members, and they begin to consider their own deeper motivations. Some discover, for example, that being caught was not just bad luck; "their behavior passively invited rather than avoided arrest." In some sense, they *sought* punishment.

In the process of group interaction, "personal passivity diminishes. The members soon discover that they can express hostility, experience anxiety, and tolerate tension without resorting to antisocial behavior. Thus the expressions of character disturbance are channeled away from the community into the group sessions where each member's behavior and attitudes can be influenced by discussion, peer interaction, and new identifications."

During the terminal phase of treatment, the Philadelphia report notes, "some men talk of positive feeling for the group and the benefit derived from it. They may express realistic gains. The most important seem to be increase in job stability and increase in self-esteem"—which for the Philadelphia program as for most others is a major goal. Some men in the terminal phase, the report adds, are still "playing the con game"; they say nice things to impress the therapist—but other group members are quick to recognize and challenge this ploy. "It is common to find members [in the terminal phase] acting as co-leader," doing their best to reinforce the therapist's attitudes.

Readers desiring a fuller account of this group process are referred to the publications from the Philadelphia program listed in the Bibliography (page 96).

After ten years of experience, Dr. Peters and his associates launched a study to determine whether these changes visible during therapy affected behavior following the termination of therapy. For this purpose, they followed up 92 alumni of the treatment program for a period of two years—and compared what had happened to them with what had happened to a generally similar group of sex offenders who had been placed on probation *without* therapy.

The two groups were different in some respects. The therapy group had committed more offenses, and more serious offenses, than the group placed on probation without therapy. If the therapy group did as well as the probation group despite the presence of men with more prior offenses and more serious offenses, it might be deemed a success.

Actually, the treatment group seemed to have fared much better than the probation group. Twenty-seven percent of the probation group were rearrested during the two-year followup period, as compared with only three percent of the therapy group. Rearrests for sex offenses were low for both groups—8 percent for the probation group versus one percent (one arrest) for the group which had received treatment.

Psychiatrists also interviewed both groups during the followup study and rated them on their adjustment to work, sex relationships, and other factors. The only notable difference between the two groups was in sexual adjustment; members of the group

which had received treatment were rated much higher.

These preliminary findings were encouraging, but subject to many qualifications. Thus 44 percent of the treatment group were there for homosexual offenses with consenting adults—sodomy or solicitation for sodomy; and 12 percent were there for similar offenses officially listed as "public indecency." Such offenses, so very commonly prosecuted in Philadelphia during the period 1955–1965, have almost disappeared from today's treatment programs. The Philadelphia findings of that era may not apply to today's mix of sex offenders. Further, the two-year followup period was short, and the use of a comparison group rather than a control group—that is, the failure to start with a common pool of offenders and then assign individuals by lot to one group or the other—limited the reliability of the findings.

Phase II. To remedy these and other shortcomings, Dr. Peters and his Philadelphia General Hospital associates launched a much more strictly designed study with funding from the National Institute of Mental Health. During this phase the program was known as The Center for Studies of Sexual Deviance. From November 1966 to October 1969, 264 sex offenders convicted in the Philadelphia courts were all subjected to the same intake evaluation procedures; they were then assigned by lot either to a therapy group or to a probation group. This is one of the very few fully controlled studies in the history of the correctional system—for obvious reasons. When a judge is sentencing an offender, he wants to determine the outcome himself—not have it depend on a subsequent flip of the coin. Similarly those who administer the intake procedure are appalled when they examine a man who clearly needs therapy—but who, by the flip of a coin, is placed on probation instead. Great ingenuity may be used in defeating the random-choice procedure. Despite these and other obstacles, random assignment proved successful in this program.

Another change was made in the Philadelphia program concurrently. Instead of being spread out among the probation staff, all sex offenders in the study were assigned to six probation officers who thus became specialists in the handling of sex offenders and their problems—a procedure which other jurisdictions are urged to study and try out. Also, the men in the treatment program were no longer required to meet monthly with their probation officers in addition. Thus the two groups were sharply differentiated—men on probation with probation officers who were specialists vs. men in the treatment program. Forty group sessions were required of the men in the treatment program, as compared with only sixteen during the prior decade.

Under these circumstances, both groups did well—about equally well. About ten percent of both groups were rearrested for a sex offense during a two- to three-year followup period. An additional twenty percent were rearrested for nonsexual offenses. *Those assigned to treatment who actually attended twenty or more group sessions did significantly better than the parole group—but this may have been due to their inherent differences* rather than to the benefits of therapy.

Numerous other findings of this second Philadelphia study will be found in Dr. Peters' 1973 report (see Bibliography).

Phase III. The current Philadelphia program represents a major innovation in one important respect: the treatment of sex offenders and non-medical services for rape victims are now both parts of a single ongoing program known as the Center for Rape Concern.

The history of this merger of services is of considerable interest. As early as 1970, the Emergency Room of Philadelphia General Hospital developed a special program for the emergency medical care of rape victims—including child victims. Subsequently, standing orders to the Philadelphia police directed them to bring all sexual assault victims to Philadelphia General. The numbers brought were substantial—1,039 victims in 1973; 1,084 victims in 1974. Of these, more than half were adults aged 18 or over, about a third were adolescents aged 13 to 17; and the remainder were children aged 12 or younger.

It soon became apparent, however, that many rape victims need non-medical care *following* treatment in a hospital emergency room. Under the direction of Dr. Peters, accordingly, a home-visit program was launched, under which a social worker was assigned to visit each victim in her home within 48 hours after her visit to the hospital emergency room, to provide supportive services and to arrange for subsequent care if indicated. Plans also called for a visit to a program psychiatrist and for three subsequent home visits spread over the following year in an effort to determine and meet the long-term needs of rape victims. This program for victims, merged with the pre-existing treatment program for sex offenders, secured funding from the National Institute of Mental Health.

The sex-offender portion of the program continues

in Phase III as in Phase II, but with several innovations. Sex offenders assigned to the program are expected to continue in their therapy groups until their probation ends or until released by the program—rather than merely for 16 weeks (as in Phase I) or 40 weeks (as in Phase II). Women co-therapists have been provided for several groups. Offenders continue to see their parole officers as well as participating in the treatment program. A special "couples group" for offenders and their wives has been added, with one male and one female co-therapist. Sex education is provided. In these respects, the Philadelphia program—for many years a stronghold of the strictly psychoanalytic approach—is moving in the same direction as the newer programs stressing a sociosexual approach. Note: Three other community programs modeled on Phases I and II of the Philadelphia programs are described in Appendix A:

Outpatient Treatment Clinic for Special Offenders, Baltimore, Md. (p. 81).

Program of the University of Southern California's Institute of Psychiatry and the Law, Los Angeles (p. 82).

Sex Offender Treatment and Evaluation Program, Violence Research Center, Denver, Colorado (p. 83).

4.3. Castration and Reversible Chemical Castration

Surgical castration is sometimes proposed—and has in the past been used—either as a form of *punishment* for rapists and other sex offenders or as a form of *treatment*.

Surgical castration is worthless as a form of punishment, however; for the castrated offender can readily reverse the hormonal effects of castration by securing at small cost periodic injections of the male sex hormone, testosterone, or of a related drug—and thus escape the intended punishment. Cosmetic surgery can erase the visible signs of castration.

As a form of treatment, involuntary surgical castration offends the ethical sense of many, perhaps most people; it is unlikely that the courts in any American jurisdiction would today approve surgical castration of an unwilling offender.[3]

A somewhat different issue was raised in the courts of California in 1973, when two 45-year-old sex offenders, both guilty of child molestation, applied to a California court for *voluntary* surgical castration. Both had been sent to Atascadero State Hospital for treatment. Both were subsequently returned to court with a finding that they were not amenable to treatment and were still "dangerous to society." The next stop would be incarceration in a California prison under the state's sexual psychopath or "mentally disordered sex offender" statute. The period of incarceration would be indefinite—quite possibly for life, with little or no possibility of parole. Faced with such a bleak future within the conventional correctional system, the men quite reasonably sought an alternative—surgical castration with the likelihood that it might lead to parole.

There were California precedents. Indeed, California courts approved voluntary castration on numerous occasions prior to 1968, when a civil suit brought by the American Civil Liberties Union against a judge and surgeon involved in such a castration put an end to the practice. To get around this problem, the two applicants for castration in 1973 filed waivers releasing their lawyers, the judge, and the surgeon from any civil liability.

Thus the ethical dilemma which society faces in these and other situations was clearly posed. The ethical conscience of the community readily tolerates life imprisonment; why should it refuse to tolerate an alternative such as castration which some offenders at least may greatly prefer to lifelong imprisonment? Is the objection in fact an ethical one, arising out of a concern for the offender, or is it a disguised punitive insistence that sex offenders be drastically punished rather than escape with mere castration?

In the 1973 California case, interestingly enough, the issue was settled without regard for the interests or wishes of the two applicants for castration. The surgeon who had initially consented to perform the operation if the court approved withdrew his consent following consultation with medical colleagues, including the Malpractice and Ethics Committees of the San Diego Medical Society. Medical Society officials informed the surgeon that the legal waivers signed by the offenders and his malpractice insurance would protect him from civil suits by the men if they were castrated—but that nothing would protect him from subsequent *criminal* prosecution for mayhem or for assault and battery. Thus the two applications for castration did not fail because of any concern for the applicants but out of a concern for the safety of the surgeon.[4]

[3] Both Nebraska and California passed laws during the 1930's providing for the involuntary castration of sex offenders, and the California law remained on the books until 1971. The Nebraska castration law was repealed earlier. European experience with the castration of sex offenders has been reviewed by Georg K. Stürup, M.D., of the Herstedvester Detention Center, Albertslund, Denmark, in "Castration: The Total Treatment" (see Bibliography).

In Europe, the possibility of a *reversible* alternative to surgical castration was opened up in the early 1960's with the discovery of a new drug, cyproterone acetate, which is a testosterone antagonist or antiandrogen—that is, a substance which negates the effects of the male sex hormone and thus produces a condition akin to castration, reversible when the antiandrogen is withdrawn. Beginning in 1966, cyproterone acetate and another drug, methyloestrenolone, have been tried out, as an alternative to long-term imprisonment, at several European clinics.

4.4. Phipps Clinic Program, The Johns Hopkins Hospital, Baltimore, Maryland

At a medical meeting in England in 1968, Dr. John Money, clinical psychologist and director of the Office of Psychohormonal Research at The John Hopkins Hospital, reported the first case of reversible chemical castration in an American sex offender—"a case of incest in the management of which Dr. Claude Migeon, Dr. Marco Rivarola, and I collaborated. The offender was a transvestite father who began to dress his six-year-old son in girl's clothes and later tried to engage him in mutual fellatio." If arrested and convicted of such an offense, of course, the father was in imminent danger of prolonged, perhaps lifelong, incarceration. His wife, who discovered the offense, called Dr. Money's Office of Psychohormonal Research rather than the police—and the outcome was therefore different.

Dr. Money's initial plan was to try cyproterone acetate, as in the European clinics, along with psychological counseling. Since cyproterone had not been cleared for such use by the U.S. Food and Drug Administration—and has still not been cleared—an alternative antiandrogen was used. Depo-Provera was given intramuscularly every week or ten days. On the dosage selected, the circulating testosterone level of the patient was reduced by more than 90 percent from the normal male level. "Behaviorally, the patient became completely impotent, lost the feeling of libido and had a remission of his compulsive dressing and incest urges. He was cooperative in accepting these changes, since he wanted to save his marriage and be reinstated with his wife. The wife and son, along with the patient, were given psychologic counseling. After one month, the dosage was reduced to 200 milligrams every 15 days, and after another two months to 150 milligrams every 15 days. On this latter dosage, plasma testosterone tended to return to normal by the end of each 15-day period. It became possible for the patient to have an erection again, though less frequently than formerly. The followup has been for six months, for which period transvestite and incestuous impulses have been in remission."

This patient's subsequent career is also of considerable interest. After a total of two years, both Depo-Provera injections and psychological counseling were discontinued. There was no return of either the urge to dress in feminine clothing or the incestuous impulses. "Intercourse continued on a 2–3 times a week basis, and without the addictive type of masturbation formerly experienced. The life style and the weekly round of activities manifested an about-face, into an almost idealized mold of the suburban husband and father."

This condition continued for an additional nine months without treatment, "at which time the patient and his family made a vacation visit in the home of a former transvestite friend who claimed to be reformed. There were several visible signs to the contrary. Upon returning home, the patient began to feel his old feeling of 'emptiness inside,' his old insomnia, and his old masturbatory compulsion. He was much afraid that he would lose all he had gained, and wondered whether he should return to Depo-Provera therapy preventively. After two injections of 300 milligrams ten days apart, his symptoms were in remission. He discontinued treatment and has remained symptom-free for ten months, as of the present writing. The total time elapsed since his first injection is now 3½ years."

At the outset of treatment, Dr. Money reported in 1970, this patient "put his female wardrobe in storage. He did not want to dispose of it, since he had no feeling of guarantee that he could permanently quit his habit. Actually, he has never returned to his clothes. More importantly, he has not felt the urge to cross-dress, and has not had to carry on an inner battle of resistance against temptation. In like fashion, there has been no temptation toward his son. In sum, there has been a psychic realignment so that bizarre eroticism, once expressed, is now negatively coded in the mind and brain, and its expression vetoed. In its place are those manifestations of love in the heterosexual relationship that were formerly prohibited, but are now positively coded and expressed."

Following this 1970 report, the patient suffered another relapse to cross-dressing. "It was brought

[4] "Everything that is not compulsory is forbidden." Before 1968, California sex offenders could be castrated against their will; thereafter even those who sought castration were denied it.

under control with another period of treatment," Dr. Money noted late in 1976. "The patient now reports for followup four times a year."

Encouraged by this case, Dr. Money and his Johns Hopkins associates over the next few years tried the same approach in a variety of other cases—eight of which were reviewed in 1970 and several more in 1975 (see Bibliography). Some patients, Dr. Money reports, welcome the "erotic apathy" which Depo-Provera produces. Others view it as a temporary "respite or reprieve from a sex life that has become too demanding and trouble-producing. While the respite lasts, something else may happen which, for lack of a better term, may be called psychic realignment"—a substitution of licit for illicit activities as forms of sexual expression. By providing a "vacation from sex drive," Dr. Money believes, the antiandrogens may make such a realignment possible in a significant proportion of cases.

In 1975, Dr. Money transferred responsibility for the program to a psychiatrist and psychiatric nurse, Dr. Michael Spodak and Ann Falck, R.N., of Phipps Clinic at the Hopkins. Dr. Spodak and Ms. Falck are now working with three groups and comparing the results: (1) patients participating only in group therapy; (2) patients on Depo-Provera receiving group therapy; and (3) patients on Depo-Provera receiving individual counseling.

One of Dr. Money's associates, Dr. Paul A. Walker, is currently director of the Gender Clinic at the University of Texas Medical Branch, Galveston. He and another graduate of the Money group, Dr. Walter Meyer, were planning, late in 1976, to launch a similar Depo-Provera program for selected Texas sex offenders. A number of physicians in various parts of the country have also used Depo-Provera with individual sex offenders.

4.5. "Behavior Modification," "Aversive Conditioning," "Brain-washing," and "Human Experimentation Without Consent"

The two programs reviewed in sections 4.6 and 4.7 below, are the only two programs among the 23 in this study which describe themselves as "behavior modification programs." Both make limited use, in selected cases, of "aversive conditioning." A preliminary discussion of these terms is necessary to avoid confusion.

From one point of view, all 20 of these programs—indeed, all conceivable programs for sex offenders—are in fact "behavior modification programs." Their major purpose and major justification is to modify the behavior of sex offenders so that society will be protected and offenders will similarly be protected from future arrests, convictions, and incarcerations. Despite the obvious value of modifying the behavior not only of sex offenders but of other criminal offenders, however, a surprisingly widespread hostility to "behavior modification" programs has arisen in some parts of the country. The objection to behavior modification appears to arise in considerable part out of hostility to a particular technique for modifying behavior—the technique known as aversive conditioning.

To start with a very simple example of aversive conditioning, a mother uses it when she scolds or spanks a small child for running out into the street. Her unvoiced theory is that an act such as running out into the street will be deterred if it is repeatedly followed by an unpleasant experience—a scolding or spanking. A simple axiom, "the burnt child avoids the fire," lies at the heart of aversive conditioning.

Incarceration may also be viewed as a form of aversive conditioning. If an offense is followed by incarceration, according to this point of view, repetitions of the offense may be deterred.

Aversive conditioning is often coupled with reward conditioning, in which desired behavior is rewarded. Thus the child who is spanked for running into the street may be given an ice cream cone at the end of a day in which he or she has played without straying from the yard.

There are reasons for believing that the very intense and vocal hostility to "behavior modification therapy" arises in considerable part out of the equating of that term with aversive conditioning. This is not, however, the whole explanation. There also appears to be a hostility in some people to any "scientific" approach to changing behavior. It is proper, they seem to believe, to incarcerate an offender for long periods. But any effort to use scientific methods of discouraging criminal behavior or encouraging socially acceptable behavior during incarceration or during probation and parole is seen as "brainwashing"—even though the offender himself may vastly prefer aversive conditioning to prolonged incarceration.

Opposition to scientific approaches in the correctional system may also arise out of the belief that such approaches constitute "experimentation with human subjects," without the consent of the human subjects.

Nor does this objection disappear if a program secures the written consent of participants; for it is

said that men under legal duress—incarcerated or on probation or parole—are not free agents and therefore *cannot* give uncoerced consent to an experimental program. This view has arisen quite naturally out of past abuses in using correctional inmates as experimental guinea pigs in programs which could not possibly benefit them but could accomplish substantial harm. The extreme reaction to these abuses, however, has reduced the correctional inmate, the probationer, and the parolee to a position in which he cannot consent to an experimental program even though it is unlikely to harm him and may be to his very great benefit.

Yet another source of hostility to behavior modification and aversive conditioning is their frequent use in the past in efforts to "cure" homosexuality—a procedure which has grown increasingly unpopular in recent years. Hostility to behavior modification for the "cure" of homosexuals appears to have "spilled over" to its use for other purposes.

The hostility to behavior modification programs and to human experimentation has been sufficiently strong to secure the abolition of such programs in several state correctional institutions, and to block the launching of one such program in the Federal penal system. Those planning new treatment programs for sex offenders should be aware of the possibility of attack on grounds of "brainwashing" or using "behavior modification" techniques, or "engaging in human experimentation." Such opposition is particularly likely if "aversive conditioning" is included in a program.

Against this background, two programs which make use of aversive conditioning—both of them independent of the correctional system—can be described.

4.6. Program at the Department of Psychiatry, University of Tennessee Center for the Health Sciences, Memphis

This program differs from all of the others here reviewed in a variety of important respects.

It is the only program which is adequately described, explained, and documented in the published literature (see Bibliography, page 95). Readers are accordingly referred to the publications there cited for a much fuller account.

It is the only sex offender treatment program whose funds come largely from a Federal grant—a grant from the National Institute of Mental Health (NIMH).

It is the only program whose patients—rapists and child molesters—are all *volunteers*. No one is sentenced to the Memphis program, nor will the program accept a rapist or child molester who is forced to apply for admission as a condition of his probation or parole. This limitation to volunteers is a condition of the program's NIMH grant.

Treatment is offered both on an outpatient and an inpatient basis. The duration of treatment ranges from three to nine months; but patients are free to leave the program at any time.

Finally, this is a *behavior modification program*. All treatment programs aim at the modifying of behavior so that offenders will not reoffend; but in the technical language of psychology, behavior modification refers to a specific approach which has three hallmarks:

- Behavior is analyzed into discrete units which can be objectively tested.
- Techniques are then devised to alter each type of behavior independently.
- Objective tests are run repeatedly during the treatment and at its conclusion to determine whether the treatment is accomplishing its goal.

Dr. Gene G. Abel, the psychiatrist who heads the Memphis program, began his research at the University of Mississippi Medical Center during the 1960's, in collaboration with three psychologists—Drs. Edward B. Blanchard, Judith V. Becker, and David H. Barlow. In 1975, Drs. Abel, Blanchard, and Becker transferred to the University of Tennessee, where they established a treatment model based on four major hypotheses:

- Most rapists are far more responsive sexually than other people to visual or verbal cues involving violence, dominance, or the infliction of pain. Child molesters are similarly overresponsive to sexual cues involving prepubertal physical development. One goal of the Memphis program is to make such cues less sexually stimulating to patients in treatment.
- Many rapists and child molesters are less responsive than other people to ordinary adult sexual cues involving neither violence nor underage partners. Specific techniques are being sought which can increase the responsiveness of sex offenders to such cues.
- Many sex offenders turn to rape or child molestation at times of extreme stress or psychological conflict. Techniques are accordingly sought which will reduce these stresses and conflicts.
- Finally, many sex offenders are so lacking in

ordinary social skills that they are unable to enter into sexual relationships not involving force or children. The Memphis program seeks to develop these skills.

There is nothing unique to the Memphis program, of course, in these four goals. Many of the other sex offender treatment programs here reviewed also seek to lessen arousal to deviant forms of sexuality, increase arousal to nondeviant sexual activities, lessen stress and conflict, and develop sociosexual skills. The analytic and testing techniques used in Memphis, however, are quite different.

With respect to social skills, for example, the Memphis researchers initially set up a very simple social situation—man meets woman, strikes up conversation, suggests a further meeting. Twenty socially skilled males and eleven socially inadequate offenders were then asked to act out this scene with a trained female partner; all 31 encounters were videotaped. Two independent raters noted the specific differences between the detailed behavior of the socially adequate and socially inadequate participants—in terms of words used, facial expressions, posture, eye contacts, gestures, tone of voice, and so on. From these videotaped encounters a measuring scale was prepared in which behaving like the socially adequate participants led to a high score while behaving like the socially inadequate participants lowered the score.

Use of this Memphis scale is illustrated by the case of a 19-year-old rapist whose history of sexually aggressive behavior began at age 13. "At that time he began cruising shopping centers, would identify an attractive female, approach her as she entered her car and grab her in the vaginal area. . . . He began raping women at age 17." By the age of 19, he had attempted rape five times and had completed the act on two of these occasions. When tested on the heterosocial skills scale, he showed serious deficits. Social skills training was accordingly prescribed—along with training designed to reduce his sexual arousal to rape cues.

The social skills procedure followed a carefully planned series of very small steps. At the first session, he met with his woman therapist, who talked with him about ways to open a conversation with a woman he didn't know—someone sitting next to him on the bus, for example. Sample one-line openings were tried; and at the end of the session he was instructed to try using such openings in the course of the coming week.

At the second session, the rapist was asked to report on his success or failure in opening a conversation during the week, and was rewarded for his account by strong praise from the woman therapist—in the language of behavioral modification, "strong social reinforcement." Next the two role-played a scene on a bus in which the rapist not only opened a conversation but continued it following the therapist's smiling response. The dialogue was videotaped, and at its conclusion the tape was played back. Thus the rapist had an opportunity to see himself as others saw him, and the therapist had an opportunity to provide further praise for the progress he was making—further positive social reinforcement. It also gave her an opportunity to call attention gently to ways in which his social approach might be still further improved. The session concluded with this dialogue:

Rapist: Well, I sure don't know everything about talking with women yet, but I've learned a few things.

Therapist: You really have. I'm pleased with how you've picked up on followup questions and statements so quickly. Knowing how to start a conversation and continue it in this way is the basis of a conversation and getting to know someone. You're doing excellent. I'm really proud of you. Now remember to practice and I'll see you next week.

The theory is, of course, that an offender who knows how to start a conversation with a woman, and to enjoy a conversation with her, is less likely to grab at her vaginal region as an opening gambit—or to rape her. The success of the social skills training is measured periodically by having the patient take the social skills test again.

The many other treatment routines developed by the Abel group, and the tests developed to gauge the need for these routines and to determine the success or failure of the training, fall outside the scope of this survey. Readers are again referred to the publications listed in the Bibliography. One additional feature of the Memphis program, however, warrants mention.

There, as elsewhere, "assertiveness training" is used when indicated to enhance a rapist's or child molester's social functioning. Assertiveness training consists essentially of practicing the art of stating *your own* feelings and opinions rather than suppressing them or superficially agreeing with someone else. "Although it may seem a contradiction in terms, some rapists are underassertive," Dr. Abel points out—and other therapists agree. "They react to interpersonal conflict with unexpressed anger and

hostility. Later this anger is overexpressed in the form of very angry, hostile, aggressive outbursts . . . or in rape behavior."

Development of the Memphis program has been slow, largely because of the requirement that only volunteers may be accepted into the program. By the fall of 1976, eleven rapists had volunteered; and by the spring of 1977, the program had enolled 35 rapists and child molesters. Plans call for following their post-treatment careers to determine whether the measurable changes in behavior which occur in the course of the program will lead to significant changes in recidivism and other measures following termination of treatment.

# # #

One technique for enhancing a sex offender's sexual responses to non-deviant sexual cues has been discussed in the published literature but has not been tried out in the Memphis program or in any other treatment program for sex offenders. This is the use of a trained "sexual surrogate" with whom the offender may actually practice the techniques of sexual enhancement pioneered by Dr. William H. Masters and Virginia E. Johnson at the Reproductive Biology Research Foundation in St. Louis. Drs. H. L. P. Resnik and Marvin E. Wolfgang, it will be recalled, discussed this approach in their 1972 essay, "New Directions in Treatment" (see page 9). It was frequently raised as a possibility by treatment program directors during site visits for this study. The only reported case of the use of a sexual surrogate in the treatment of a sex offender, however, comes from outside the correctional system.

In 1973, Dr. Robert J. Kohlenberg, a psychologist at the Center for Psychological Services and Research, University of Washington, Seattle, reported on the treatment of a 35-year-old male, Mr. M., who had been twice arrested for molesting male children and was fearful of further arrests. "The patient considered his sexual orientation to be homosexual, but he became aroused only with young males of about 6 to 12 years of age. He claimed that he 'prowled' or actively looked for sexual contacts with male children about twice each week by going to a playground or swimming pool where he would be likely to see children. Mr. M. reported that this 'prowling' or active looking did not currently result in sexual contacts but did result in both sexual arousal and subsequent discomfort and distress. . . . Fantasies during masturbation were also centered on male children and masturbation occurred several times a week.'

The patient reported occasional sexual contacts with adult males; but these were unsatisfactory and never ended in orgasm for him. He could not recall "ever being attracted to adult females and claims his only self-satisfying contacts have been with male children."

Mr. M. was not, however, content with his lot. He "stated that his desire for children was immoral and had ruined his life. He had sought treatment twice before and had had three years of individual and one year of group therapy. Mr. M. felt this therapy has given him some understanding of his behavior but had not led to any changes in his desire for young males."

Dr. Kohlenberg's treatment plan for this patient involved two phases; the use of aversive conditioning in Phase I to lessen his responsiveness to male boys; plus the use of the Masters-Johnson approach in Phase II to enhance his responsiveness to male adults. To check on the effectiveness of the treatment, the patient was instructed to keep a daily record showing (a) the number of times per day his thoughts were centered on male children, (b) the number of "prowling" incidents, and (c) the number of sexual encounters with adults who were sexually arousing.

The first four weeks of treatment were devoted to preliminary interviewing. The record showed high levels of thinking about male children and prowling in search of them, but no sexual encounters with adults. The next four sessions were devoted to aversive conditioning. There was no improvement. Dr. Kohlenberg accordingly proceeded to Phase II.

"The basic goal of this phase was to produce sexual arousal and orgasms for Mr. M. with an adult male partner." Dr. Kohlenberg states, "Since the therapy was to involve a series of sessions attended by Mr. M. and a sexual partner, the first task involved finding a suitable partner. The requirements for the sexual partner were as follows: (a) he was to be at least 30 years old; (b) he was willing to commit himself to attending at least ten weeks of therapy sessions and at least two encounters with Mr. M. during [each] week; and (c) he was willing to follow the therapeutic regimen which included sexual encounters that did not lead to orgasm. Mr. M. contacted a 32-year-old man, Mr. C., who met the above requirements. Mr. C. had been an acquaintance of Mr. M for several years and was willing to participate out of friendship for Mr. M.

"The therapy sessions were conducted on a once a week basis with both Mr. M. and Mr. C. present. . . Instructions were given for Mr. M. and Mr. C.

to engage in at least two encounters during the week. These first encounters were to take place with both men in bed without clothes. As described in Masters and Johnson for heterosexual couples, they were instructed to take turns giving each other sensate pleasure. Touching, caressing, etc., of any kind was permissible, but there was to be no touching of the genital or anal area and sexual arousal was not a goal.

"During the second treatment session of this phase, Mr. M. reported that he was very tense and perspired profusely during the previous week's encounters with Mr. C. Mr. C. found the encounters pleasant and arousing.

"According to Masters and Johnson, a primary source of inhibition to sexual arousal is that of performance anxiety wherein the patient acts as an 'observer' of his own sexual behavior. In the present case, Mr. M. seemed to have been concerned about his performance during the previous week's encounters and was also concerned about Mr. C.'s negative evaluation of his own (Mr. M.'s) lack of sexual arousal. The importance of eliminating the observer role and its inhibitory effects was emphasized to Mr. M. and Mr. C. Mr. C. reassured Mr. M. that it was okay with him if Mr. M. did not become sexually aroused. A restatement of the goals for the coming week's encounter was made. The goal was to become relaxed and have pleasant feelings; sexual arousal was not a goal.

"The second week of encounters was reported to be relaxing and pleasant by Mr. M. Mr. M. incidentally, reported that he also became sexually aroused.

"The following steps were taken during the remainder of the program. Instructions to proceed to the next step were given only after the patient was completely relaxed at the preceding item: (a) touching for sensate pleasure, no genital involvement; (b) touching for sensate pleasure, some exploratory touching of genital area; (c) simultaneous genital touching, orgasm not permitted; (d) simultaneous genital touching and belly rubbing with genital contact, orgasm not permitted; (e) no restrictions, orgasm permitted.

"The last step of treatment was reached during the thirteenth week of Phase 2. Mr. M. was seen six months later for a followup interview, at which time he turned in daily reports covering some of the previous six months' behavior.

"The primary result of treatment was that Mr. M. became sexually aroused with Mr. C. as a partner. Reports of fantasy during masturbation also indicated that Mr. M.'s sexual object was becoming older. Mr. M. also reported that he found other adult men attractive and had sexual contacts with adults (other than Mr. C.) that were sexually arousing. . . .

"Mr. M. reported that he had become less preoccupied and attracted to children. He ceased 'prowling' for children after the sixth week of Phase 2 treatment, and at the six-month followup he reported that he had not actively sought any sexual contact with children since the termination of treatment."

The patient's daily record confirmed the success of the treatment. Mr. M.'s "prowling" ceased altogether after the 15th session—except for a single incident reported at the 22nd session. Sexual thoughts of male children became much rarer—one or two a week—at about the same time. And also at about the same time, sexually arousing contact with adult males began and continued. In this particular case, the carrot had proved more effective than the stick; the enhancement of arousal to adult male stimuli had succeeded in lowering the response to immature male stimuli after aversive efforts to accomplish that goal had failed.

At least two women experienced in the heterosexual surrogate role using the Masters-Johnson approach are known to have discussed with treatment program staffs the possibility of using a similar procedure with heterosexual sex offenders, and to have volunteered their services. The political risks of attempting such a procedure, however, have acted as a deterrent. So far as is known the heterosexual surrogate approach has not been tried.

4.7. The Center for Behavior Modification, Minneapolis, Minnesota

This center is a private, free-standing psychological clinic which accepts private clients of many kinds. More than a hundred of these clients over the past five years have been sex offenders—self-referred or referred by physicians, prosecuting and defense attorneys, probation and parole officers, and others. Each client is treated in accordance with a schedule individually tailored to his circumstances. Most of the treatment of these sex offenders has been provided by William W. Duffy, a psychologist who is executive director of the center, or by others under his supervision.

Despite the Center's use of the term "behavior modification," the psychological treatment of many sex offenders at this clinic is quite similar to treatment at other psychological or psychiatric clinics which do not use the term. The same counseling

procedures are used, goals are set, problems are discussed, and so on. The prime difference is in theory rather than practice. Duffy sees his program as an effort to modify behavior by rewarding behavior which is socially acceptable and which can take the place of the socially hazardous behavior. The primary reward used, as in other programs, is the therapist's approval—plus the self-rewarding effect of behaviors which the offender finds enjoyable and socially acceptable. For a minority of sex offenders, however, "aversive conditioning" is also used—that is, techniques designed to deter unwanted forms of behavior.

Duffy cites as a typical case one 27-year-old married man referred to the center after having committed eight rapes. From the age of 12, "this individual compulsively masturbated using women's undergarments and extremely deviant sexual fantasies" as modes of arousal. Subsequently "he began acting out these fantasies and started assaulting women sexually." Duffy's analysis of this sequence is that the masturbatory orgasm constitutes a very powerful reward which reinforces and encourages repetition of the immediately preceding behavior until it becomes compulsive.

"The aversive conditioning program used for this individual," Duffy continues, "consisted of using a combination of women's undergarments paired with sexually deviant fantasies" as masturbatory stimulants, as in the past. Now, however, the behavior occurred in a private room at the Center for Behavior Modification. At specified points in the procedure, the client received an unpleasant shock (eight milliamperes for half a second) in his forearm. Thus the stimuli (women's undergarments and deviant sexual fantasies) were followed by an aversive shock rather than by an orgasmic reward.

A major feature of behavior modification therapy is its effort to secure *objectively measurable* changes. In this case, the measure of change was the time elapsing between the onset of the procedure and the occurrence of sexual arousal and deviant fantasies. At first, arousal occurred within 20 seconds or so. This "fairly quickly progressed to latencies of over four minutes. In other words, after a series of . . . shock pairings, it became more difficult for the client to engage in . . . sexually deviant behaviors. Additionally, pornographic films depicting fetishes and violent interactions were paired with shocks. The results were similar to the initial aversive conditioning trials."

In due course, Duffy reports, "the client stated that it was too anxiety-producing to . . . engage in sexually deviant behavior," either at the center or outside. At this point, aversive conditioning was discontinued and "attention was turned to positive behavior-change counseling procedures."

Marriage counseling was provided for the client and his wife, from whom he was separated; this "subsequently led to a therapeutically wise divorce." The client was also counseled "in such areas as dealing more effectively with his parents . . ., vocational counseling and educational counseling. Since the client was a fairly bright but underachieving individual, much emphasis was placed on having him enroll in the University of Minnesota and to begin preparing for a new vocational area. The subsequent success this client experienced was in part greatly facilitated by the initial . . . aversive conditioning. Instead of being continually preoccupied with deviant fantasies and being in constant fear of compulsively raping a woman, this man was able to devote his concentration and energies to learning a more functional and socially acceptable repertoire of behaviors." Though couched in the language of behavioral modification, the process is clearly similar to that in other programs—*after* the aversive-conditioning phase.

"On followup, approximately two years after the onset of treatment at the Center," Duffy adds, "this client would occasionally have fantasies related to undergarments," but "he was able to control these fantasies and not reinforce them through masturbation. In place of these fantasies he was able to substitute more appropriate sexual fantasies and to reinforce these through masturbation. Additional counseling was aimed at helping him broaden his social interaction in general."

4.8. The SOANON Program, Los Angeles

This is a free-standing, non-profit program, organized personally by an ex-sex offender, Richard Bryan, and his wife Rosemary. SOANON stands for Sex Offenders Anonymous; and the program has a self-help structure modeled after Alcoholics Anonymous except for the religious component of AA. SOANON accepts referrals from probation and parole officers but is otherwise independent. Groups meet in churches or other public buildings. The modest expenses are met by contributions from the participants themselves; the Bryans donate their services.

Richard Bryan is a disciplinarian with very firm views on how sex offenders can and should discipline

themselves. A sex offender whose mode of operation is to pick up hitchhikers for sexual exploitation, for example, is instructed to bolt the right-hand door of his car permanently shut, so that if an impulse to pick up a hitchhiker arises, the bolted door will constitute an obstacle. Similarly, exhibitionists and other sex offenders are instructed to wear a device which takes several minutes to unlace and remove—in the hope that the device will constitute a barrier to a sudden compulsion to exhibit or masturbate the penis, and that the compulsion may pass during the distracting minutes it takes to remove the device. In addition, of course, SOANON provides the usual mutual support and practical help and guidance common to other self-help groups. In addition to group meetings for offenders, there are meetings for wives only, and for wives and offenders together. SOANON works with professional therapists, accepts referrals from them, and refers members to professional therapists when indicated.

PART V. CONCLUSIONS AND RECOMMENDATIONS

Most convicted sex offenders today, as noted above, are treated precisely like other convicted offenders; they are lodged in the same cell blocks in the same correctional institutions, or they are released on probation or parole under the same supervisory arrangements. No special heed is paid to the specifically sexual problems which led to their past sex offenses—and which may lead to future sex offenses.

The 20 existing and three discontinued sex offender treatment programs described in this survey are the exceptions. They have explored many new approaches to the sex offender problem. These Conclusions and Recommendations are based largely on the experience thus accumulated.

But many possible approaches remain unexplored as yet; and barely a beginning has been made in coordinating the efforts of the numerous agencies concerned with sex offenses within each state and metropolitan area. These Conclusions and Recommendations will therefore go beyond the experience of treatment programs to date, suggesting several as yet untried approaches and stressing the need for areawide and statewide coordination.

5.1. The Need for Statewide Planning

Instead of thinking solely of individual treatment programs serving the sex offenders who happen to be immured in a particular state mental hospital or correctional institution, or who happen to be on probation or parole in a particular metropolitan area, future thinking about and planning for sex offender programs should be concerned with the whole broad flow of sex offenders found guilty by the courts. Minnesota, as noted above in section 1.9, has proceeded farthest in this direction. A statewide Minnesota plan covering all convicted sex offenders is currently being drafted and is scheduled for completion in August 1977. Other states similarly should view their problems as a whole rather than limiting themselves to isolated programs in particular institutions or communities.

Emphasis is here placed on statewide rather than national or local planning because most sex offenders are convicted in state courts of violating state laws, and many are sentenced to state institutions. There is also an opportunity, however, for the *local* coordination of programs in a metropolitan area—including plans for those on probation or parole in the area and those lodged in local institutions. Similarly, there is a role for a national concern with the problem—including the launching of a national organization of sex offender treatment programs and treatment program personnel; a national newsletter and other communications facilities which will bring existing and projected programs into touch with one another; a national program for evaluating treatment programs and for disseminating the evaluation findings; and a national policy of funding pilot projects and innovative approaches which give promise of becoming useful national models.

Both those preparing statewide plans and those involved at the local and national levels should be concerned with at least eight sex-offender categories:

1) Juvenile sex offenders.

2) Volunteers—offenders who have not as yet fallen afoul the criminal law but who voluntarily seek treatment because they are concerned with their socially unacceptable patterns of sexual behavior and with the hazard of future arrest and conviction.

3) Nuisance offenders. Examples are exhibitionists, voyeurs, fetishists, and others who are commonly arrested and released with a warning, or placed on probation, or sentenced to a short term in a local correctional institution (jail). With these offenders as with common drunks, the result is often a species of "revolving-door justice"; little is accomplished either for the individual offender or for society.

4) Rapists, child molesters, and other serious offenders convicted in the state courts and sentenced to incarceration—but with sentences suspended and probation mandated.

5) Serious offenders incarcerated for treatment in state mental hospitals.

6) Serious offenders incarcerated in medium-security and minimum-security state correctional institutions.

7) Serious offenders incarcerated in maximum-security state correctional institutions.

8) Offenders released on parole or aftercare status following incarceration in a correctional institution or state hospital.

In the sections which follow, we shall consider treatment programs for each of those eight categories in turn.

Statewide planning projects and national organizations should be concerned with all eight major categories. Local groups should have a particular concern with offenders remaining in the community: juveniles, volunteers, nuisance offenders in local institutions, sex offenders on probation, and sex offenders on parole or aftercare status. Almost any metropolitan area will find, if it examines its local situation, that it has far more sex offenders (including serious offenders) remaining in the community than it has lodged in institutions.

Within the eight major categories, numerous subgroups can be recognized. Offenders with intact families, for example, may benefit from treatment procedures (such as family therapy) inappropriate for single, separated, divorced, or widowed offenders—and vice versa. Incest offenders (see Section 2.10) may benefit from a special program and so may offenders with a basically homosexual orientation. Future studies will no doubt reveal significant subgroups within the juvenile sex-offender category. A statewide planning project should be concerned with the extent to which it is both advisable and feasible to address the specialized needs of such subgroups.

5.2. Planning for Juvenile Sex Offenders

In any large metropolitan area, as noted in section 2.16 above, there are 15-year-old rapists, heterosexual and homosexual, 15-year-old child molesters, exhibitionists, voyeurs, and fetishists; the entire range of adult sex offenses can be found at the juvenile level. These cases are commonly processed through the juvenile courts and the juvenile correctional and probation and parole systems—systems overburdened with other problems and rarely staffed or equipped to address the specifically sexual problems of juvenile sex offenders.

For several reasons, a concern with juvenile sex offenders should be placed high on the priority list of all state planning projects, national organizations, and local groups concerned with sex offender treatment programs. First and foremost, these young people are in urgent need of treatment. Second, there is every reason to hope that treatment will prove effective if made available early in the process which develops an adult sex offender. Further, we desperately need additional data concerning the factors, before and after puberty, which produce sex offenders; these data will almost certainly emerge from programs which address the specifically sexual problems of these juvenile sex offenders.

At least three *caveats* must be attached, however, to this recommendation. First, any program for juveniles must scrupulously distinguish between serious juvenile offenses and the ordinary learning and "horsing around" experiences, heterosexual and homosexual, which are common features in the developmental histories of law-abiding citizens as well as of sex offenders. Second, care should be taken to minimize the adverse impact of *labeling* a juvenile as a sex offender (see page 35). Third, treatment should be made available both for juveniles in the community and for those lodged in juvenile correctional institutions. If treatment in *both* settings is not available, as noted frequently above, judges will be under pressure to send to institutions for treatment juveniles who do not need incarceration—or to leave in the community for treatment those who are unsafe to be at large.

5.3. Planning for Sex Offender "Volunteers"

Lawyers, psychiatrists, clinical psychologists, mental health clinics, community mental health centers, and other local agencies are from time to time approached for help by prospective patients or clients whose behavior places them in jeopardy of being arrested and convicted as sex offenders tomorrow, next month, or next year. During the research for this study, indeed, its author was thus approached on several occasions for advice on where to find treatment. Some of these volunteers for treatment have past arrest or conviction records; some do not. They come seeking help; what help is available to them?

Some practitioners and agencies, public and private, see these volunteers as falling outside their proper function and send them away or refer them elsewhere. Others would like to be helpful but don't know how. Still others provide therapy or counseling—but may do so in relative ignorance of the many available alternatives.

A start in improving services to volunteers might be made by calling a one-day conference, in any major metropolitan area, for personnel in the helping professions and for interested social agencies. (For

an example of such a conference for persons interested in *juvenile* sex offenders, see pages 35–36.) Such a conference might be concerned with three goals: improving the services offered by practitioners and agencies which accept patients or clients in this category; informing other practitioners and agencies of where they can refer volunteers; and devising methods of encouraging potential sex offenders to volunteer for treatment *before* arrest and conviction. Two obvious modes of encouragement are a "hot-line" which an offender can call at the moment he feels he needs help, and an absolute assurance (based on state law) that his confidences will be respected. A statewide planning project might be concerned with fostering conferences and hot-lines in the state's major metropolitan areas, and with sponsoring whatever amendments to the state's confidentiality laws may be needed to encourage volunteering.

5.4. Planning for "Nuisance Offenders"

Society appears to be in the process of reducing the incidence of "nuisance" sex offenders simply by redefining the term "sex offense." A significant example is the transvestite or cross-dresser—the male or female who customarily or on occasion appears in public in the apparel of the other gender. Even a decade ago, transvestites were commonly found serving time in jails and even in prisons; some were also sentenced to treatment programs. While quantitative data are not available, knowledgeable observers agree that arrests and incarceration for cross-dressing are much less common today. The popularization of slacks, jeans, and other traditionally male apparel among women, in fact, make it almost impossible to define or identify female cross-dressing.

It is possible that, in some communities, exhibitionists and voyeurs are similarly being tolerated rather than arrested and convicted. Some women in the women's movement, however, are quite properly concerned that this may be going too far. They see "peeping" and "flashing" as an at least symbolic assault on women, and quite properly want both modes of behavior curbed. They insist, with very good reason, that a woman in the privacy of her home should be free of the annoyance of being peeped at, and that a woman at home or away from it should be free from being confronted with a view of male genitals which she has no desire to see. The question is thus whether arrest, conviction, and punishment are the best ways to discourage peeping and flashing.

The available evidence indicates that, as with other forms of "revolving-door justice," very little is accomplished. Peepers and flashers may continue their behavior following dozens or scores of arrests, convictions, and jail terms. The establishment of treatment programs for peepers and flashers may accomplish little; but the odds are good that such programs will prove at least *slightly* more effective than processing through the courts and the correctional system—and no more expensive.

Suggestions have repeatedly been made that peepers and flashers be encouraged to attend nudist resorts and other places where nudity is legally tolerated (see, for example, page 8 above). The common answer is that for the voyeur, the excitement of peeping is dependent upon his doing so surreptitiously, without his being observed; and that an exhibitionist's interest in exhibiting is similarly dependent on the "startle reaction" of the woman to whom he exhibits—a reaction which would fail to occur, of course, in a setting where everyone is nude. *These objections, however, are based on no evidence whatever.* No one has introduced a dozen peepers or a dozen flashers to a nudist setting and reported that there was no change in the subsequent incidence of peeping of flashing. It is time at least to try.

Meanwhile, the purveyors of pornography in many cities are offering their own solution for the peeper who does not want to risk arrest. For a modest sum, a peeper can stand or sit in an enclosed booth and watch an incredible variety of sexual scenes portrayed on a screen in front of him. In some establishments, he may watch a live woman strip off her clothes and engage in sexually provocative behavior while he himself remains unobserved in his booth. In some European cities there are similarly night-club settings where male exhibitionists can display their penises in public and even masturbate. Perhaps, it may be said, more can be accomplished for civic order by making such facilities available than by fruitless revolving-door procedures of the criminal justice system.

One objection to this approach is that the public availability of peeping and flashing facilities may increase the incidence of such behavior by attracting patrons who would not otherwise peep or flash. Another objection is that peeping and flashing are commonly found in the sexual histories of more serious sex offenders—rapists, for example. Peepers and flashers, it is therefore said, should be punished

or treated *before* they progress to more serious offenses.

The latter notion, however, has little practical merit. A parallel from the field of illicit drug use will make this clear. Years ago, superficial students of the drug problem observed that almost all heroin users smoked marijuana before they tried heroin. This led them to the view that marijuana leads to heroin and that suppressing marijuana would help solve the heroin problem. Experience has now shown that, while almost all heroin users were former marijuana smokers, a very small proportion of marijuana smokers in fact progress to heroin. Either in the presence or absence of marijuana, some alcohol drinkers progress to heroin, too. Thus the total suppression of marijuana would have little if any effect on heroin consumption. Similarly, the suppression of peeping and flashing by legal sanctions is unlikely to have even a slight effect on the incidence of rape.

The major justifications for providing treatment for peepers, flashers, fetishists, and other nuisance offenders are to abate the nuisances they cause—and to help them live more fulfilling lives. Peepers, flashers, and fetishists are not notably happy people likely to reject alternative modes of sexual fulfilment if they could find enjoyable alternatives. Nobody knows whether a treatment program based on sex education, the development of social skills, the repair of damaged self-images, and the building of self-esteem could open welcome alternatives for them, for few efforts have as yet been made.

In sum, a statewide planning project should consider alternatives to the revolving-door system of justice for nuisance offenders—the repeated arrests, convictions, suspended sentences, and jail terms or longer-term incarcerations at high social cost with negligible payoffs. No very high priority can be given to this problem, since rape and child molestation obviously have a greater claim on limited societal resources. But the problem is widespread in some cities and neighborhoods; it should no longer be handled solely by processing nuisance offenders through a revolving door.

5.5. Planning for Serious Offenders on Probation

One basic problem here is how to determine which serious offenders can safely be treated on probation and which should be incarcerated. This issue will be considered below (section 5.11).

The fact is, however, that some offenders who have committed such serious offenses as rape or child molestation are today being placed on probation; and that first offenders, offenders who exhibit no violence, offenders who appear to be good candidates for rehabilitation, and perhaps other subcategories will in fact be placed on probation under almost any changes in the criminal justice system. How should they be treated while on probation?

The first and simplest approach, pioneered in Philadelphia (section 4.2) and Baltimore (section A.7), is to build up expertise *within* the probation system. This means providing specialized training and supervision for a particular probation officer or small group of officers, and then assigning to them all sex offenders on probation. An opportunity for frequent and intensive consultation with treatment program staffs and other experts in the vicinity should be a part of the training and supervision.

In addition, Parts II and IV above and Appendix A below describe a wide range of community-based treatment programs addressed to the specifically sexual problems of sex offenders on probation. (See in particular Sections 2.10–2.15, 2.18–2.20, 4.1–4.8, and A.7–A.9.) A statewide planning project should review and perhaps visit those community-based programs on this list which appear to be relevant to the state's concerns and resources.

In the course of the Minnesota statewide planning project, as noted above, it became clear that a surprising number of public and private clinics, community mental health centers, family service agencies, child welfare agencies, drug treatment programs, and other community resources were already directly or indirectly concerned with the treatment of sex offenders. Incorporating these agencies into the statewide plan, eliciting the cooperation of additional community agencies, and providing coordination and consultation among agencies should be one function of any statewide or local planning project.

No example was found, in the course of this survey, of a half-way house or hostel for those sex offenders on probation who need this kind of facility. In Minneapolis several drug treatment programs with live-in facilities accept sex offenders as well as drug offenders; and in Florida, plans are on the drawing board for a hostel-type facility. Both statewide planning projects and local groups concerned with sex offender problems in a particular metropolitan area should consider the need and feasibility of providing intensive treatment in an open, community-based hostel or half-way house—both for sex offenders or probation and for those who are now

serving time in local jails but might better be treated in such a facility.

5.6. Planning for Serious Offenders Incarcerated for Treatment in State Mental Hospitals

This is an area of very high priority for statewide planning projects in the many states where sex offenders are currently being held for treatment in state hospitals—but are being provided with little or no treatment directly addressed to their sexual problems.

In the first place, both state and federal courts have repeatedly held that it is unconstitutional to incarcerate an offender in a hospital for treatment without providing treatment. There is a considerable likelihood that future decisions will similarly hold it unconstitutional to hold a sex offender for treatment in a hospital where the available treatment is irrelevant to his needs. This is peculiarly true where the laws provide for continuing incarceration until the treatment is successful.

Even in the absence of court intervention, such a "Catch-22" situation should be intolerable to the conscience of society. Yet in *most* states, state mental hospitals today hold sex offenders for whom the only treatment available is treatment addressed to the needs of the criminally insane, psychotic patients, and others having little or nothing in common with the needs of sex offenders. It is surprising that states which follow this irrational pattern do not suffer from even higher recidivism rates than the current rates.

This holding of sex offenders in hospitals which offer little or no treatment relevant to their needs is peculiarly abhorrent because it is so unnecessary. The costs of providing *relevant* treatment are no higher than the costs of providing the irrelevant treatment currently provided. Indeed, several of the mental hospital programs listed in Parts II and IV above and in Appendix A below are actually spending less per patient on their sex offender programs than on their programs for criminally insane, psychotic, and other patients. Starting a program addressed to the specifically sexual problems of sex offenders in a state hospital which already holds sex offenders requires little or no additional staff or resources—merely the sound redeployment of existing staff and resources.

Numerous models for sex offender programs in state hospitals have been presented above and will be presented in Appendix A below; see especially sections 2.1–2.9, 3.1–3.4, and A.2–A.3. A statewide planning project should review these programs in detail, make visits to selected programs, and either provide treatment programs for sex offenders in all of the state's mental hospitals or else provide for the incarceration of sex offenders only in those hospitals which have treatment programs addressed specifically to the sexual problems of sex offenders.

5.7. Planning for Serious Offenders Incarcerated for Treatment in Medium-Security and Minimum-Security Correctional Institutions

The U.S. correctional system has lagged behind the mental health system in establishing treatment programs for sex offenders. The discontinued Wisconsin program (section A.4), the two New Jersey programs (sections 3.3 and A.6), and the Colorado State Reformatory program (section A.5) are the only four operating under correctional auspices found in the course of research for this survey. In addition, there is the Massachusetts program (section A.1), housed within a correctional institution but operated under mental health auspices.

Statewide planning projects need not limit themselves, however, to these four or five models. Most features of the treatment programs in the state mental hospitals can be equally well introduced into medium-security and minimum-security state correctional institutions if two basic prerequisites are met:

a) The program should be operated as an enclave within the correctional institution, responsible for its own security and staffing, with the sex offenders housed together in the separate unit and provided to the fullest extent feasible with other facilities independent of the rest of the institution.

b) The program should be adequately staffed, at both the professional and paraprofessional levels, with personnel dedicated to the goals of the treatment program and fully qualified by education, experience, or both, for their roles in the program.

Granted independence and appropriate staffing, it probably makes little difference whether a program is lodged in and administered by a correctional system or a mental health system. A correctional system can base a treatment program on any of the state hospital models described in this survey, or can borrow features from those models in designing its own program.

5.8. Planning for Serious Offenders Incarcerated for Long Terms in Maximum-Security Correctional Institutions

Here are found the most serious of all sex offenders—those serving long terms for crimes involving major violence, including some who fit the Krafft-Ebing stereotype—lust-murderers, rape-mutilators, and the like (see page 2). An argument can be made against providing treatment at all for these major offenders.

If treatment is provided early in their incarceration, it may be said, it will be wasted—since no judge or parole board will release them no matter how successful treatment appears to be. Nor is treatment toward the end of a long sentence of any use, since long years of incarceration in a maximum-security institution produce a "convict personality" which ruins a man for a treatment program based on honesty, openness, and the building of self-esteem.

A partial answer will be found in section A.5, where a program for rapists serving terms of 25 years or longer in New Jersey's maximum-security institution is described. Such programs may not accomplish much, but they may be better than no program at all. Further, significant data may emerge from such programs—data which may help prevent future sex offenses and the rise of another cohort of major offenders from among today's children and young people. While a program for those serving long terms in maximum-security institutions is hardly a high-priority concern of a statewide planning project, it warrants careful consideration.

5.9. Planning for Sex Offenders on Parole

As is the case with sex offenders on probation, sex offenders on parole following incarceration need and can benefit from much more intensive treatment than is commonly provided parolees.

At a minimum, parole departments, like probation departments, should develop a competence and expertise in the handling of sex offenders—by providing special training and supervision for one or a few parole officers in each area, and by assigning all paroled sex offenders to those specially qualified officers (see section A.7). The possibility that the same qualified officer or officers be employed to handle both probationers and parolees is worth considering and perhaps trying out—though the major differences between probationers (who are in general new to the criminal justice system) and parolees (who have already served time) should not be overlooked.

As with probationers (section 5.5), parolees may benefit from a halfway house or hostel where intensive treatment can be provided during their period of readjustment. The possibility may be considered of a halfway house serving both probationers and parolees—once again, with an awareness of the differences between these two groups.

As in Albuquerque (section 2.18), community-based treatment programs serving primarily sex offenders on probation may also involve themselves with sex offenders on parole—and the same is true of other community agencies and resources.

Reviewing these and numerous other parole possibilities should be given a very high priority by statewide planning projects and by local planning groups. It is self-defeating to spend large sums on the incarceration of sex offenders, with or without treatment during incarceration, and then to turn them loose in the community with little assistance or supervision during the critical weeks and months when they are learning again how to live in freedom. The period of parole following incarceration in a correctional system or of work release following incarceration in a state hospital is the period when a sex offender's resolve to avoid reoffending will be either reinforced or destroyed. He needs and deserves all the help society can provide.

There is little reason to believe that the programs for paroled offenders reviewed in this survey are the best possible models. Just as Hank Giarretto in Santa Clara County, California (section 2.10), developed a wholly new model for treating incest offenders on probation and their families, so other innovative professionals should be encouraged to develop innovative community-based programs for other types of offenders on either probation or parole. The funding of pilot projects in this area should have a high priority among federal, state, and private funding agencies (see below, section 5.13).

In planning programs for offenders either on probation or on parole, state and local planning groups should bear in mind that two major subcategories of offenders—those with intact families and those without—may need and benefit from quite different procedures.

5.10. Modernizing the Criminal Laws

Very early in its deliberations, any group considering the future of sex offender treatment programs will find itself face to face with major difficulties

arising out of the gravely outmoded provisions of state criminal statutes defining and governing sex offenses. In most states, acts no longer deemed criminal by the conscience of the community are still defined as criminal, and subject to very harsh penalties. Adultery, fornication, and sexual acts in private between adults of the same sex are a few striking examples from among the many available (see above, pages 3–4). Even though such laws are only rarely enforced in most states, there is much to be gained by eradicating them from the statute books rather than relying on law enforcement authorities to refrain from enforcing them. To encourage respect for law, states should make their laws respectable.

Another problem which should be faced concerns the "age of consent," especially as it affects child molestation. An adult who engages in sexual acts with a six-year-old, for example, is clearly engaging in child molestation, regardless of whether the child protests or willingly participates. But suppose that the "child victim" is 18 years old—and not only consents but initiates the encounter? Where shall the line be drawn?

New Mexico and several other states have responded by drawing two lines—setting the age of consent at 14 or thereabouts for sexual conduct in general, but at or close to 18 if the adult participant is the father or other close relative, or a guardian, teacher, physician, clergyman, scoutmaster, or other adult *in a position of authority*. This proposal also eliminates the traditional incest laws; it is no longer the blood relationship which determines the offense but the sexual exploitation of the young by adults with authority over them.

In some states judges have almost unlimited power to turn a convicted offender loose or sentence him to any term including long-term or lifelong imprisonment. In other states, judges are left with little or no discretion; a conviction for a specific offense such as rape may carry a *mandatory* sentence which a judge may increase but may not decrease. Considering the degree of discretion which judges should have when sentencing sex offenders may prove necessary in considering ways to improve a state's handling of sex offenders. Improvements in parole procedures may also prove desirable or necessary.

Repeal of outmoded state "sexual psychopath" statutes is also being urged in some quarters (see section 1.2 above). A few features of these outmoded statutes, however, should be retained (see below).

Some state criminal statutes provide that certain categories of sex offenders—rapists, for example—shall not be eligible for parole. This means that on the completion of their sentences they will be turned loose in the community without even the minimum of services and supervision commonly provided for parolees. A more sensible law would provide precisely the opposite—that no serious offenders (such as rapists) be released from correctional institutions *except* on parole.

This is hardly a comprehensive account of the ways in which modernizing a state's criminal statutes may improve its responses to the problem of sex offenses. The examples cited, however, should be sufficient to alert state and local agencies to the need for sex law reform.

5.11. Improving Sentencing Procedures

Whether an offender is placed on probation, or sentenced to a treatment program, or sentenced to serve a term in a conventional correctional institution without treatment, depends in large part on the judge's decision at the moment of sentencing—and judges have relatively little data available to guide their decisions. They must rely in part on their "hunch" at the time of sentencing; in part on a psychiatric report (if there is one), often based on a single psychiatric interview with the offender; and in part on a conventional probation report which may (or may not) tell more about an offender's sexual problems than is shown on the face of his prior arrest-and-conviction record.

One of the few merits of the outmoded "sexual psychopath statutes" is a sound solution to this problem. These old statutes provided, and still provide in some states, that following conviction for a major sex offense, a judge may commit a sex offender to a treatment program for a period of observation not exceeding 60 or 90 days (see section 2.1 above). During this observation period, the experienced staff of the treatment program, and the other sex offenders in the program, have an opportunity to study the convicted sex offender in depth, to see how he reacts in a variety of situations and to reach an informed opinion concerning the two points at issue: (1) does he need incarceration or can he safely be left on probation in the community, and (2) if he is to be incarcerated, will he benefit from the treatment program available in this institution or should he be committed elsewhere? Following the observation period, the sex offender is then returned to court with a recommendation for sentencing—and with the detailed grounds for the recommendation. The judge can thus reach a decision with some confidence that he is not acting capriciously. States

not currently using this procedure should institute it; and states currently using it should retain it even though they may repeal other provisions of their sexual psychopath statutes.

A cautionary note should be sounded, however. It is easy for a state's judges to inundate a sex offender treatment program with large numbers of sex offenders sent for observation—so that little space or staff resources remain for the major function of the program, treating patients. The observation period as an aid to judicial sentencing will work only if the treatment program is provided with the necessary diagnostic resources—without impoverishing its treatment resources.

A serious problem in some sex offender treatment programs is the receipt from the courts of offenders who are wholly unsuited to the program—either because they are not in need of incarceration or because they are unlikely to benefit from the treatment available. To avoid being clogged with unsuitable offenders, a treatment program should have a veto power over its own admissions—the power to refuse admission to an offender either because he is not suitable or because there is no room for him. Along with this should go the power to transfer an offender to another part of the institution, or to return him to court for transfer elsewhere.

5.12. Release Provisions

A statewide planning project should concern itself similarly with the provisions for the release of offenders following successful completion of treatment. Specifically, *a sex offender who has successfully completed a treatment program and who is returned to court or to a parole board with a recommendation for release on parole or aftercare status should be assured of release.* Otherwise, the whole treatment program becomes a farce unable to command the cooperation of either offenders or staff.

One program experienced the disastrous effects of a failure to abide by this principle two years ago. It returned to court, with a recommendation for release on parole, two sex offenders whose rehabilitation was obviously complete. Both men had gone through the changes described in earlier sections of this survey and had become leaders within the program. One was described as "our best man" and was offered a paid professional job within the program following his anticipated release. The blow to both staff and offender morale when these two program graduates, despite the program's recommendations for release on parole, were sentenced to life imprisonment on return to court can readily be appreciated. The program was only able to survive the blow by assurances that every effort would be exerted both to correct these miscarriages of justice and to prevent recurrences.

The time to prevent such disasters, obviously, is when an offender is first sentenced to a treatment program. Judges should be informed that a sentence to the program carries with it a commitment to release the man on parole following successful completion of the program. In any case where the judge is unwilling to make this commitment, he should not sentence the offender to the treatment program. In states where release is dependent upon the parole board rather than the sentencing judge, parole authorities should similarly agree in advance that successful completion of the program will be a ticket to release on parole. Offenders not eligible for such an agreement should not be admitted to treatment programs.

This is *not* a novelty within the correctional system. It is merely the application to sex offenders of a concept known as Mutual Agreement Programming (MAP), available to other offenders in at least a dozen states. Under the MAP plan, an individual offender can enter a *legally binding agreement* with the correctional system and parole board at an appropriate point in his incarceration. The agreement specifies precisely what the offender proposes to do toward his own rehabilitation during a specified period of time; and it provides that if the offender lives up to his part of the agreement, the parole board is legally bound to release him at the end of the period specified.

"The MAP concept has been tested experimentally in Wisconsin, Arizona, and California with favorable results," William Parker reported in 1975 (see Bibliography). "Currently, both Michigan and Wisconsin have extended MAP statewide, and it is being tested on a pilot basis in Maryland, Maine, Florida, North Carolina, and the District of Columbia. The New York State Department of Probation is testing its use in four counties with probationers; Alabama is testing it with parolees contracting for early release from parole; and both Maryland and Massachusetts have received grants from the Law Enforcement Assistance Administration to test [a modification of the MAP contract]. Models have been developed and are under consideration" in eight other states. "In addition, the Canadian federal authorities are in the process of using MAP as the basis for modernizing programs of rehabilitation."

Applying the MAP contract to sex offenders in treatment programs is even simpler and more logical than its use elsewhere in a correctional system. Instead of requiring the development of an individual treatment plan for each offender, the MAP contract can specify release when the established treatment program is successfully completed.

5.13. The Funding of Treatment Programs

Incarcerating an offender in a state correctional institution costs considerably more than the cost of room, board, tuition, and incidental expenses for a student at the state's university—indeed, a year in most correctional institutions costs more than a year at Harvard or Yale. Much the same is true of the cost of holding a sex offender for a year in a state mental hospital.

As noted above, it costs little or nothing more to provide a sex offender with *relevant* treatment in a state hospital than it does to provide the irrelevant modes of treatment most state hospitals now provide; indeed, it may cost less. Though data based on experience are not available, the same may also prove true for treatment programs in medium-security and minimum-security correctional institutions. The cost of additional treatment personnel may be balanced by a saving in correctional personnel not needed by treatment programs which maintain their own security. The redeployment of existing funds, personnel, and resources rather than additional funds, personnel, and resources may prove sufficient or almost sufficient in many situations.

Where additional funds are needed, the state legislature which already supplies funding for state mental hospitals and correctional institutions is the obvious source of the additional funds as well. State legislatures are notoriously loath, of course, to supply more than minimum funding for such institutions, and very few politically potent pressure groups exist to urge more adequate appropriations. In the case of sex offender treatment programs, however, there are numerous possibilities for securing very powerful support at appropriation time.

Judges are one group highly sensitive to the folly of sentencing sex offenders to institutions which provide no treatment, or inadequate treatment, or irrelevant treatment. So are prosecutors, defense attorneys, psychiatrists, psychologists, social workers, community service agencies, and others concerned with the problems of sex offenders. Equally concerned are the women's groups involved in anti-rape programs and disturbed about child molestation. But the power these groups represent must be mobilized.

It is here that a statewide planning project can have major impact. In the course of its planning activities, such a project will consult with all of the helping professions and agencies concerned, and will seek to secure their support of the plan decided upon. Thus the stage is set for mobilizing the support of these powerful cooperating forces when the funding of the plan reaches the state legislature.

The funding of community-based treatment programs for sex offenders may prove more difficult. Such programs can hardly be launched through the redeployment of existing funds and resources; they require additional expenditures. But the same politically powerful forces which can be mobilized to support institutional treatment programs can be mobilized to support community programs recommended in a statewide plan.

It costs much less, of course, to treat an offender in a community-based program than in an institutional setting; the enormous costs of providing room, board, and security are avoided. In the absence of community-based programs, many sex offenders who do not need incarceration will inevitably be incarcerated. Thus it can be argued that expenditures on community-based programs can be recouped at least in part by savings in institutional expenditures.

Legislators are commonly skeptical of such arguments for indirect savings, and perhaps rightly so. But another argument, if cogently presented, is likely to strike a more responsive cord. Everyone, including members of legislative appropriations committees, is concerned to curb sex offenses. Despite even the harshest laws, the vast majority of sex offenders and potential sex offenders are at present and will inevitably remain free in the community—including juvenile offenders, unconvicted offenders, offenders on probation, and those released on parole or work-release status. Community facilities constitute one bulwark against further offenses by these offenders. A community which fails to provide community-based treatment programs is thus much like a community which fails to provide police protection. This argument, which can and should be fully documented in the course of planning for treatment programs, can be cogently presented to local and state appropriating bodies by the powerful forces in the community which help prepare the plan.

Two other potential sources of funding deserve mention: federal agencies and foundations or other private philanthropies.

Since correctional services are state and local

functions, federal agencies refuse to fund the operating expenses of sex offender treatment programs—and rightly so. Foundations and other private philanthropies similarly refuse to supply operating funds for what are properly governmental functions. But there are at least three possible exceptions to this rule.

First, federal funds may be available for the *planning* of treatment facilities. Thus Minnesota's current project for preparing a statewide plan was funded by a grant to the state from the Law Enforcement Assistance Administration. Funds from local foundations may similarly be available for planning.

Second, either federal funds or private philanthropic funds may be available for the launching of *pilot projects* likely to prove of value as models for other programs. As noted above, a few innovative programs have in the past secured such "seed money" from the Law Enforcement Assistance Administration, from the National Institute of Mental Health (including its National Center for the Prevention and Control of Rape), and from private foundations.

Third, either federal funds or private philanthropic funds may be available for the *independent evaluation* of treatment programs—again on the theory that the funds will prove useful to treatment programs in general rather than solely to the program being evaluated. (For a general consideration of evaluation procedures, see Appendix B, pages 85–92).

Finally, federal or private philanthropic funding may be available for the training of personnel (see below). The securing of both federal funding and foundation or other private philanthropic funding, however, commonly proceeds in two stages. There must first be a decision on the part of the funding agency to devote funds to a particular field or activity. Only following that initial decision does the second issue arise: what particular projects within the field shall be funded? Federal and private funds for sex offender treatment programs are in very short supply in part because there has as yet been no decision that this is an area worth funding.

It is possible that the April 1977 meeting of treatment program directors (see pages viii-ix) will consider this problem and take steps to call attention to the need for both federal and private funding—not for routine treatment program operations but for planning, pilot projects, evaluation, and the training of personnel. It is possible also that this survey of existing treatment programs will influence federal agencies and private philanthropies to include the fostering of such programs in their future funding plans.

5.14. The Staffing of Treatment Programs

Whenever a new business enterprise or agency, private or public, is launched, a qualified staff must be assembled. Three ways are commonly recognized for finding qualified personnel. One is to hire them away from existing business enterprises or private or public agencies. A second is to consult educational institutions where qualified personnel are trained. The third is to provide on-the-job-training. All three are relevant to the launching of new sex offender treatment programs—and all three involve major difficulties.

Existing treatment programs are small, few in number, and very meagerly staffed. Thus "raiding" them to staff new programs, though it no doubt will occur, will hardly solve the personnel problem. Not until treatment programs are expanded far beyond their present size and number will the raiding of old programs provide a significant amount of staffing for new programs.

So far as can be determined, moreover, no educational institution in the country is currently providing training in the sex offender field at either the professional or paraprofessional level. The need for such training will become increasingly visible as plans for new programs are developed. A statewide plan might therefore properly include a provision for a training program to be launched in one of the state's educational institutions. The first few such training programs are likely to attract participants from all over the country as well as from the states where they are located.

Finally, provisions for on-the-job training should be included in any statewide plan.

Federal agencies and foundations or other private philanthropic agencies may also develop an interest in this problem of staffing new programs. Funding might help in either of two respects: by helping to establish training programs in one or more educational institutions, or by funding existing treatment programs to train personnel for new programs.

The crucial importance of including *women* in the staffing of treatment programs at all levels, often stressed in prior sections of this survey, should be stressed once more in connection with the training of treatment program personnel.

5.15. Geographical Considerations

It has long been the policy of most states to locate

their correctional institutions and state mental hospitals in rural areas remote from centers of population. This policy represents a major handicap for sex offender treatment programs, as well as for other programs, for several reasons reviewed in prior sections: a remote location makes it difficult to recruit and hold qualified staff, and difficult or impossible to include the families of sex offenders in the program; and it also makes liaison between the program and its patients on parole or aftercare status difficult or impossible. For all of these reasons, statewide planning projects should do everything possible to encourage the siting of new treatment programs close to the centers of population from which their future staffs and offenders will be drawn.

5.16. Program Size

While a state should plan treatment facilities for all of its convicted sex offenders likely to benefit from treatment, each particular program should remain relatively small. Some program directors felt that for an institutional program, 75 offenders constitute a reasonable maximum; others suggested a ceiling at 100. Institutional programs which grow beyond that size lose the intimate association among the offenders, and between the staff and offenders, described above as a major factor in rehabilitation. Instead of expanding a program beyond the appropriate ceiling, a new program should be launched at another site.

If a new structure is built to house sex offenders, keeping it small is of special importance. It is an axiom of institutions that any bed which exists will be filled. Historical examples are numerous of institutions which kept themselves full, despite a declining need for their services, by admitting and holding patients or inmates who might equally well be cared for on the outside. The time to avoid unnecessary incarceration is when planning new structures. Building them small is the best assurance that they will be used only for those actually in need of incarceration.

Much the same considerations apply to community-based treatment programs. A program which grows too large loses its personal quality—and can readily become a neighborhood nuisance. Several community-based programs strategically sited in various parts of a metropolitan area are better than one overgrown program.

Starting a program with a very small offender group has major advantages, as an example will show. Several of the programs here described suffered "growing pains" during their early months. The program director may have visited Fort Steilacoom or South Florida and may have noted the high morale, the self-reliance, and the sense of responsibility displayed by the participants in those programs. When he launches his own program, however, the results are very different. The men cheat, lie, steal, and shirk, sabotage, conspire, and complain—in short, behave like "cons."

The highly skilled director of one outstanding drug treatment program in a correctional setting describes his formula for avoiding such an outcome—a formula equally applicable to sex offender programs.

"I started this program with just two participants," he recalls, "myself and my associate director. Together, over a period of several weeks, we planned the entire program, wrote out the schedules, set the rules, allocated space, spelled out our goals.

"Next we interviewed all of the eligible offenders in the institutional population and selected the one man who seemed best suited for a leadership role. We admitted him to the program and went through the whole planning process again with him. 'They won't buy that one,' he'd remark, or 'why don't we do it this way instead?'

"When the three of us were unanimous and constituted an ongoing, functioning team, we admitted two more carefully selected offenders. We didn't consult with them; we told them how things were to be—but we were alert to what worked and what didn't. Then we revised our program again until the five of us were working well together. All this took about three months.

"From there on, it was easy. New men were admitted one or two at a time, and promptly adapted themselves to the prevailing customs—including absolute honesty and openness, loyalty to the program, and so on. They wanted to be *insiders;* and we had established in advance the rules for becoming an insider. Tradition is a major factor in the success of any program; the best way to establish sound program traditions is to start very small and very slow."

The small slow start is strongly recommended for new sex offender treatment programs, both institutional and community-based.

5.17. A Look Backward—and Ahead

This first review of sex offender treatment programs is hardly a definitive study; the time has not yet come for that. Similarly, the Conclusions and Recommendations here presented are far from comprehensive. Many questions remain unanswered. This is

a field for pioneering and a time for pioneering. Altered public attitudes toward sex and toward sex offenses (see above, page 5) have rendered the experience of past decades largely irrelevant to current problems. Recent treatment programs have opened up many new possibilities—but many more remain to be explored. Let us hope that a decade hence, or even five years hence, the next nationwide survey of sex offender treatment programs will find far more programs in operation, each with more data to report—so that a far broader range of Conclusions and Recommendations can be presented.

APPENDIX A. NINE ADDITIONAL TREATMENT PROGRAMS

The programs treated in this Appendix fall into three distinct groups:

1) Three institutional programs under the auspices of state departments of mental health (the Massachusetts program at Bridgewater, Mass.; a Florida program at the Florida State Hospital in Chattahoochie, Fla.; and a California program at Patton State Hospital in Patton, Cal.)
2) Three programs under correctional auspices (the Wisconsin program at Waupun State Prison, discontinued in 1970 but of substantial historical significance; the program at the Colorado Reformatory, Buena Vista, Colo.; and the program at the New Jersey State Prison, Trenton, N.J.)
3) Three community-based programs (at the University of Maryland, Baltimore; the University of Southern California, Los Angeles; and a program at the Violence Research Center, Denver, Colorado, discontinued in April 1976.)

A.1. Center for the Diagnosis and Treatment of Sexually Dangerous Offenders, Bridgewater, Mass.

Massachusetts enacted a "psychopathic personality" statute for sex offenders in 1947 and a modified version, the "sexually dangerous persons" law, in 1954; but it was not until 1959 that a "Center For the Diagnosis and Treatment of Sexually Dangerous Offenders" was established at the Massachusetts Correctional Institute in Bridgewater.

Administratively, this Massachusetts program is a hybrid. The center is under the jurisdiction of the Massachusetts Department of Corrections and is housed in a superannuated structure within a maximum security institution. The treatment program, however, is in the hands of the Department of Mental Health. From 1960 until August 1976, the program was under the direction of a psychiatrist, Dr. Harvey L. Kozol. For many years, treatment at Bridgewater meant primarily psychiatric treatment with both individual and group psychotherapy; in recent years, several innovative features have been added.

To a greater extent than any other treatment program, the program at Bridgewater accepts and retains "hard-core offenders whose likelihood of rehabilitation is minimal." It has no alternative; for unlike most programs, it has neither the power to refuse admission to an offender found to be sexually dangerous nor the power to transfer an offender to another maximum security institution if he proves not amenable to treatment. Inmates at Bridgewater are stratified into maximum-security, moderate-security, and minimum-security groups; but even so, the presence of substantial numbers of inmates not amenable to treatment constitutes an obvious drag on the treatment of those able to benefit from treatment.

A second major handicap is the almost medieval primitiveness of Bridgewater's physical facilities. For many years this primitiveness was exacerbated by overcrowding as men sentenced to Bridgewater stayed on year after year with little hope of being released as "cured." A court decision has now made it easier for long-term inmates to secure release *without* a determination that they are no longer dangerous. Each offender is entitled to a review of his case by a court once a year; and the burden is now on the state in such cases to prove he is still dangerous. As the years roll by, this burden of proof becomes harder to maintain and prosecutors are less eager to maintain it. The result is two streams of sex offenders leaving Bridgewater—one composed of men whose treatment has been judged successful and the other composed of men who are deemed still dangerous by the treatment program but who the courts are no longer willing to keep incarcerated. As a result of this and other factors, the overcrowding has been relieved; the census is down from more than 150 to about 90. Further, funds have been appropriated by the state legislature for a new building. The new building and the retirement of Dr. Kozol make it very likely that Bridgewater's future will not resemble its past.

A primary interest of Dr. Kozol and his associates through the years has been "the diagnosis of dangerousness." A steady stream of papers on this subject and on the character of sex offenders has emerged

from Bridgewater (see Bibliography, pages 97–98). One recent paper in this series—by Dr. Murray Cohen, Dr. A. Nicholas Groth, and Richard Siegel—presents a noteworthy review of features found in the histories of many sex offenders.

- He had a history of repetitive difficulties with women.
- There was an overidealization of some women and a fear of, and contempt for, others. Psychological pain brought about by an experience with an idealized woman resulted in feelings of anger displaced onto other women.
- A supernormal posture of self confidence thinly veiled a sense of worthlessness, inadequacy and helplessness. A premium was placed on aggression as the method for rectifying or re-establishing a sense of well being. Thus aggressive behavior was high on the response hierarchy with little ability to control its expression.
- He did not perceive the active part he played in putting himself in situations with women which could have no consequence other than his feeling used and hurt. His experience was that he was a helpless victim.
- He had no real, intimate attachments to either men or women, and as part of this isolation, the emotional qualities of compassion, love, warmth, empathy and trust were noticeably absent.
- His general mood state was dysphoric, characterized by a dull depression, but at times the depression would become acute and lead to a sense of panic and overwhelming feelings of hopelessness. Once again agression was his characteristic way of fending off the distress of the depression.
- He was a steady and good worker, but he refused to take a promotion with its attendant increase in responsibility. Although errors or mistakes at work caused him great discomfort, he received no great pleasure from good work or accomplishments.
- Although, in general, perception, attention, reasoning and judgment were relatively intact, serious impairment in these basic perceptual-cognitive functions would occur under stress.

During recent years, Bridgewater, like the other programs here reviewed, has tended to add more and more supplemental approaches to the basic medical-psychiatric model—approaches more closely targeted toward the characteristics of sex offenders listed above. A visit to Bridgewater in the fall of 1976, immediately after Dr. Kozol's retirement, produced the impression, however, that such activities constituted relatively little of the patient's total experience.

A.2. The Florida State Hospital (Chattahoochie) Program

Florida State Hospital is a large mental hospital serving the entire state except for the four southeastern counties served by the South Florida State Hospital (see above, page 22). The hospital's Forensic Unit is a medium-security unit for mentally ill persons from the criminal justice and correctional systems—including persons found unable to stand trial by reason of insanity, persons found not guilty by reason of insanity, and mentally ill inmates transferred to the hospital from the state's correctional institutions. Persons found guilty of sex offenses under Florida's sexual psychopath law may also be committed to the hospital.

Prior to 1974, the sex offenders were held and treated in the Forensic Unit's general population. This is a pattern still common in many state hospitals. Unlike the vast majority of others held in such hospitals, however, few sex offenders give any obvious evidence of being "mentally ill." In 1974, accordingly, a Florida psychiatrist, Dr. Benjamin Ogburn, launched a Sex Offender Program within the Forensic Unit, designed to meet so far as possible the special needs of the sex offender group. After two years, this program appears to be a conscientious and competent effort to adapt the state hospital milieu to the needs of sex offenders. The program stands midway between the "total push programs" as Fort Steilacoom and South Florida (pages 22–25, above) and the "minimal programs" found elsewhere.

Like the rest of the hospital, Florida State's Sex Offender Program follows the medical-psychiatric model.[1] A newly admitted offender spends his first months in a ward where there is heavy emphasis on diagnosis and evaluation by the usual psychiatric team—a psychiatrist, a social worker, a psychologist,

[1] Like other psychiatric programs, however, Florida State appears to be moving more and more toward a social-educational model. "Our future plans," Dr. Ogburn wrote late in 1976, "include . . . a ward for sexual education and social skills. We feel that we have a certain number of patients who are intellectually and educationally somewhat deprived. These patients' primary offenses, we feel, are due to their lack of knowledge and lack of social skills. They have been unable to make meaningful relationships with peers and with members of the opposite sex due to these problems." Sex education, social skills training, heterosexual recreational programs, and other programs involving contacts with women will be developed "in a very carefully supervised and structured atmosphere."

and a nurse. In the course of evaluation, the patient's program for the months ahead is prescribed and scheduled.

All patients are assigned to therapy groups which constitute the heart of the program. Each therapy group is composed of ten to fourteen patients plus a member of the professional staff and a member of the nursing staff; one of the co-therapists is always a woman. Each group meets two or three times per week for 1½ hours per session. These therapy groups are concerned specifically with each patient's problems as a sex offender. The remainder of his schedule is composed of activities in which he participates with patients from other parts of the Forensic Unit. The available activities, and the number of sex offenders assigned to each, are listed below:

Occupational Therapy Programs	100 patients assigned
Vocational Training School	27 patients assigned
Patient Labor Program	9 patients assigned
"Freedom of Movement" Activities[2]	38 patients assigned
Art Therapy Program	65 patients assigned
Music Therapy Program	22 patients assigned
Bible Study	12 patients assigned
Alcoholics Anonymous	28 patients assigned
Recreation Programs	125 patients assigned

After a period of months, the offender is transferred from the admission ward to one of the sections of Ward 10 East, a ward with a capacity of 42. While in Ward 10 East, he is encouraged to participate in all of the activities to which he has been assigned, and he is oriented to his new situation by other patients. In particular, he is indoctrinated with the Patient Ward Government rules, which are set jointly by the staff and the Patient Government. Periodically, his activities schedule may be modified, either at his request or by staff decision.

A patient earns transfer from Ward 10 East to the 42-bed advanced ward, Ward 10 West, whenever he meets certain standards; these standards concern "the patient's attitude toward treatment, his motivation toward rehabilitation, his ability to accept and demonstrate responsibility." Some patients move to the advanced ward quite promptly; others may remain in Ward 10 East for long periods—or may never reach the advanced ward.

As patients in the advanced ward demonstrate increasing reliability, they become eligible step by step for various "freedom of movement activities"—permission to leave the ward to visit some other part of the hospital with a companion, then without a companion, and eventually even freedom to leave the hospital grounds without a companion for attendance at college classes, for vocational training, or for wage-paying jobs in the "patient labor program." Thus the patient sees himself as climbing a ladder—much as at Fort Steilacoom.

Of even greater importance, the advanced ward is structured—like Fort Steilacoom and South Florida—to build group rapport and group interaction throughout most of the 168 hours of the week. Group therapy sessions in this ward are held three times a week instead of two. The 14 members of the therapy group are assigned to the same sleeping quarters; this, Dr. Ogburn reports, "promotes an air of togetherness and confidence plus a chance to discuss problems and feelings at times other than group sessions. The patients also receive peer pressure to 'live as you preach.' Peer pressure is felt by the staff to be one of the most important aspects of ward living situations"—as at Fort Steilacoom and South Florida. "It can be very effective in modifying undesirable behavior problems."

Patients who complete the advanced ward program successfully and who are deemed ready for release are returned to court with a release recommendation; the average length of stay before this happens is about two years. Patients who do not earn a release recommendation may be transferred out of the Sex Offender Program and into other parts of the Forensic Unit; or they may be returned to court with a recommendation for transfer to another institution.

A major advantage of the Chattahoochie program from the point of view of other state hospitals planning sex offender programs is the ease with which existing patterns of operation can be modified to make room for the new program. The program requires little or no additional staff or facilities—merely a redeployment of existing staff and facilities. The sex offender program thus becomes an accepted and inconspicuous part of the hospital structure, along with the other programs. It is still too early to gauge how much is lost—in terms of intensity of treatment and of ancillary activities specifically designed for sex offenders (such as sex education and sociosexual training) in the Chattahoochie model as compared with the "total push" Fort Steilacoom and South Florida programs.

Chattahoochie is located close enough to Tallahassee, the state capital and site of the state university,

[2] See third paragraph below.

to make possible exchange of staffs and the use of visiting volunteers. Because it draws its patients from almost all counties in a very large state, however, visits from the families of patients are hard to arrange in many cases, and the involvement of families in the treatment program is very nearly impossible for most patients. Because more than 60 counties are served, moreover, it is exceedingly difficult to maintain close relationships with the judges throughout the state who send offenders to Chattahoochie—and who must approve their release.[3]

A.3. Patton State Hospital (California) Program

Offenders committed under California's sexual psychopath laws are known as "mentally disordered sex offenders" (MDSO's) and were, until recently, commonly committed to the Atascadero State Hospital. All offenders requiring maximum security are still sent to Atascadero; but in the fall of 1975, a second California program was launched at Patton State Hospital near San Bernardino, an hour-and-a-half drive from Los Angeles, for medium-security offenders from the southern portion of the state.

The program was barely six months old when visited in the spring of 1976; but preliminary indications were that Patton might develop into an important center. Its founder and director, Dr. Frank Vanesek, a clinical psychologist, was formerly on the staff at Atascadero State Hospital and is familiar with the self-help-group approach pioneered at Fort Steilacoom. He has adapted features of these and other programs to the conditions prevailing at Patton. The Patton program's "treatment philosophy," as explained to entering sex offenders, is in some respects reminiscent of Fort Steilacoom's:

Treatment is Learning. Irresponsible behavior is learned. Treatment therefore is a re-learning process.

The Learning Objective is Responsible Human Relationships. The offender has treated other human beings as mere objects for his own use and pleasure. He must learn to govern his behavior by respect for the feelings and rights of other human beings.

The Vehicle of Learning is the Guided Self-Help Learning Group. Learning happens best when the learners themselves are expected to carry the major responsibility. The role of staff is to organize, guide, and assist small self-help groups.

The Material of Learning is Everyday Reality. If learning is to be a realistic and potent experience, treatment must reflect, magnify, and deal with the demands of community living. The learner must be faced with real choices and decisions every hour of the day, and must learn to make decisions on the basis of honesty and concern for others.

The Price of Discharge. A free society is held together by a network of contracts, written or unwritten, to respect each other's rights. The offender is released when he demonstrates responsible daily behavior and sensitivity towards others which follow adequate insight into his problems and irresponsible behavior.

Treatment Approach. The length of an offender's stay is based on his accomplishment of certain definite objectives. These objectives are (1) recognition of his hurtful behavior patterns; (2) understanding of the origin and operation of these patterns; (3) acceptance of responsibility for changes; and (4) application of new patterns of responsible behavior in dealing with people.

During his hospital residence the offender is under the watchful eyes of his psychotherapy group and staff, but he is given ample opportunity to interact with other patients, staff, and visitors every day. His thoughts, feelings, and behaviors are then closely monitored in group psychotherapy sessions. The offender's progress is measured by the increased understanding and better self-control he is able to achieve as well as by his demonstration of greater concern and a more responsible manner of relating to people—the basic treatment objective.

Like other state hospitals, Patton is understaffed. The Sex Offender Treatment Program has been attempting to eke out the available staff through training arrangements with Loma Linda and California Polytechnic Universities, and with other educational institutions in the area. Approximately half of the staff is female; and the presence of women trainees and volunteers from the educational institutions also helps to provide a comfortably heterosexual ambience. Much emphasis is placed, as at Fort Setilacoom, on the learning of simple sociosexual skills—how to greet a woman acquaintance, how to establish eye contact, how to start a conversation, and so on.

Family visits are encouraged and there are facilities or plans for involving families in family and marital counselling within the program. There has also been outreach to community programs in the Southern California area, in an effort to establish arrangements for the aftercare of patients returning to the community.

[3] Following conclusion of this survey, a third Florida program for the treatment of sex offenders was established at Gainesville (see Appendix C, page 93).

As at South Florida and elsewhere, there is emphasis on each man discovering his own "early warning signals," and men leaving the program are assured that "help is as near as the nearest telephone."

Because it is the most recently established program, still facing the difficulties of any new venture, the Patton program may be of particular interest to others planning new programs. Patton also demonstrates the way in which a new program can borrow features from a variety of established programs, adapting them as necessary to the local situation.

A.4. The Wisconsin Program (1951–1970)

Wisconsin enacted a "sexual psychopath law" in 1947 which was so obviously unjust and unworkable that a citizen's committee was established to draft a better law—and to plan a treatment program which might actually be of use to incarcerated offenders. The improved law was passed in 1951, and that same year a treatment program for sex offenders was established at Wisconsin's maximum security institution, Waupun State Prison.

Under the Wisconsin law, persons prior to incarceration had first of all to be convicted of a sex offense, with all the usual constitutional safeguards. Following conviction but before sentencing, judges were required to send serious sex offenders to the treatment program for a 60-day observation period. This mandatory observation period applied to offenders guilty of rape, "assault intending rape," and several other serious sex offenses. In addition, judges could, at their discretion, similarly commit for observation persons found guilty of lesser sex offenses or sex-motivated offenses. The treatment program was required to return the convicted but still unsentenced offender to court within 60 days, with a finding that he either was or was not a "sexual deviant"—a term not defined in the law. In practice, this meant that the treatment program could decide whether the offender (a) needed treatment, and (b) could benefit from treatment.

During its first eleven years of operation (1951–1962), the Wisconsin program received 2,125 sex offenders for observation and kept 901 of them for treatment.[4]

[4] 918 offenders were deemed not to be "sexual deviants" and were returned to court for sentencing under the ordinary criminal laws; 87 were found to be psychotic or mentally deficient and were transferred to appropriate non-correctional institutions; 209 were found to be "sexual deviants" but were released on probation; and 10 cases were disposed of in other ways.

What kinds of offenders were treated? More than half were child molesters (mostly convicted of "indecent behavior with a child"). The second largest group was composed of 139 men found guilty of "sexual perversion"—in almost all cases homosexual acts. During the eleven-year period, only 43 rapists and 54 rape-attempt offenders entered the program for treatment—as compared, for example, with 414 in the program for "indecent behavior with a child."

The basic approach of the Wisconsin program was psychiatric; sex offenders were there to receive individual psychotherapy from psychiatrists or clinical psychologists much as in private psychiatric practice. That approach soon foundered, however; for enough psychiatrists and clinical psychologists could not be recruited. Hence group psychotherapy was added to individual psychotherapy as a more economical mode of treatment. It soon became apparent, in Wisconsin as elsewhere, that group therapy has numerous other advantages, in addition to low cost, in the treatment of many sex offenders.

During most of its 20 years, the Wisconsin program was headed by a clinical psychologist, Dr. Asher R. Pacht, with Dr. Seymour L. Halleck, then professor of psychiatry at the University of Wisconsin, as chief consultant. In a number of respects, the Pacht-Halleck team found, Wisconsin's sex offenders resembled its other offenders:

"Most of our patients come from lower socioeconomic groups. Their histories often reveal severe trauma and emotional deprivation during early childhood. Broken homes as well as excessive drinking and promiscuity on the part of their parents are commonplace." Other programs have reported similar findings.

Drs. Pacht and Halleck continued, "Our experience indicates that sex deviates, as a group, function in the world as inadequate individuals. They are impulse-ridden, show poor controls in most areas of their lives, and have considerable difficulty in experiencing the possibility that they have some role in their own destinies. We have been impressed by the overwhelming passive needs of our population. They constantly verbalize their lack of responsibility for their behavior and express a desire for somebody to provide direction for them." These findings, too, are common to other treatment programs. Therapy is addressed in part to altering these factors—impulsiveness, lack of control, passivity, and so on.

The major shortcomings of the Wisconsin program stemmed from the fact that it was housed in a maximum security institution and had very little autonomy within that institution. Sex offenders in

the treatment program lived and worked with the other correctional inmates. They were subjected to the same institutional routines and discipline. Thus the few hours a week they spent in psychotherapy was only a part of their total institutional experience. In many respects, the routines of a maximum-security institution operate at cross-purposes with the goals of a therapy program—and this was true in Wisconsin.

One very serious handicap in the Wisconsin program was the absence of female participation. Few maximum-security institutions in the 1950's permitted women inside the prisoner areas; Wisconsin was not one of them.

Many sex offenders are married, and a remarkable proportion of their wives stick with them despite their conviction and incarceration for sex offenses. Married offenders, several studies suggest, do better following release than those without family ties. The Wisconsin program did what it could to enhance the value of such ties through the use of *family therapy*. In this approach, Dr. Pacht explained, "the entire family is seen as operating in a maladaptive fashion. It is the dysfunctional family rather than the individual that is helped to develop the requisite social climate that will lead to offender rehabilitation." Several of the newer programs make intensive use of family therapy; wives are familiar figures within these programs. But alas, Dr. Pacht pointed out, "we tend to build our institutions as far from civilization as possible. It is therefore, difficult for families to participate." The Wisconsin program was remote from the state's major centers of population.

Remoteness also made it difficult to staff the Waupun treatment program. "It is unfortunate but true," Drs. Pacht and Halleck noted, "that mental health disciplines, particularly psychiatry and psychology, have not encouraged their finest members to enter the correctional field. . . . This field has still, with few exceptions, negative status value." Adding geographic remoteness to the low prestige of jobs in a correctional institution and to relatively low payment scales for professional therapists, made staff recruitment a continuing bottleneck.

To overcome these and numerous other handicaps, Drs. Pacht and Halleck hoped and expected that the Wisconsin treatment program would in due course be established as a separate institution where the entire milieu, 168 hours per week, could be shaped to therapeutic ends, as was done at Fort Steilacoom and South Florida. The new institution was to be built near Madison, the state capital, close to the University of Wisconsin to ease staffing problems. After years of delay, however, the Wisconsin legislature ultimately refused to appropriate funds for a separate institution, and the program at the Wisconsin State Prison was discontinued.

Sex offenders committed under the 1951 Wisconsin statute are currently held at the Waupun State Hospital, an institution where treatment addressed to the specifically sexual problems of sex offenders is not available, and which therefore falls outside the scope of this study.

An outstanding feature of the Wisconsin program, rare in programs today, was the inclusion almost from the beginning of a *research component*. Statistical data were maintained on those admitted to the program for observation, on those admitted for treatment, and on those paroled following treatment. In 1965, a study was published of 461 sex offenders paroled between July 1951 and June 1963; all were followed up for a period of two full years.

Of the 461 parolees, Dr. Pacht and Dr. Leigh M. Roberts reported, only 29 (6 percent) committed new sexual or other criminal offenses during the subsequent two years. This was much better than the records of a comparable group of non-sex-offenders—15 percent of whom committed new criminal offenses during the two-year period following their release on parole.

The 6 percent recidivism figure should not be taken as evidence that the Wisconsin program performed miracles. The evaluation of a treatment program is a highly complicated matter, involving far more than a crude recidivism rate during a relatively brief two-year followup period. A program's recidivism rate may be low because it accepts only the most readily treatable cases, or because it holds for very prolonged periods all but the very best bets, rather than because it is doing a good job. There is rarely an answer to the question: would the men actually released have done equally well *without* a treatment program? These and other evaluation issues are considered in Appendix B (p. 85).

Nevertheless, the crude 6 percent Wisconsin recidivism figure makes it clear that despite the treatment program's numerous handicaps and shortcomings, and despite the relatively short duration of the treatment it offered,[5] it was not turning loose hordes of dangerous "sex fiends" eager to resume without delay their sexual depredations on women and children. Followup studies from other treatment programs confirm this reassuring view.

[5] More than two-thirds were held and treated for less than 18 months; 39 percent were held and treated for less than one year.

A.5. The Colorado State Reformatory (Buena Vista) Program

The Colorado State Reformatory is a medium security institution; inmates are in general younger and are serving shorter terms than those in the state penitentiary. The Buena Vista treatment program for sex offenders was launched in the reformatory in 1972 by Dr. Nancy Steele, a clinical psychologist. All inmates involved in sex offenses are assigned to the treatment program—whether or not the technical offenses of which they were convicted were sexual.

Treatment consists essentially of one group session per week lasting an hour and a half. There are four such groups, all led by Dr. Steele and each comprised of from seven to ten men. In addition, Dr. Steele is available for individual therapy sessions to the extent that her schedule permits.

Two of the groups, Dr. Steele explains, "are for men who were primarily aggressively (rather than sexually) motivated for their offenses. Frequently they are older than the men in their twenties or early thirties who comprise the bulk of the reformatory population. Many are married and have led very active sex lives. Some of these men have been quite successful academically and vocationally. Their central emotional problem is anger—anger which they cannot express toward the important women in their lives. Therapy, therefore, centers upon techniques for dealing with anger which are less socially damaging than rape or assault."

The other two therapy groups are comprised mostly of what Dr. Steele calls "sexually inadequate offenders. These men are generally younger; many of them are single and lacking regular sexual partners. They have failed to adjust vocationally and socially as well as sexually. Their offenses are motivated primarily by a sexual urge. Frequently their victims are relatively helpless—children, older women, the physically handicapped. They rarely use weapons, and may run away if a victim offers resistance." One goal of Dr. Steele's therapy with these men, as in a number of other treatment programs, is to build up their sense of self-worth, of competence and adequacy. Dr. Steele believes that academic and vocational training may contribute, along with group therapy, to these goals.

Newcomers to Dr. Steele's groups, like newcomers to other programs, commonly begin by denying any responsibility for their offenses. They explain that they were victims of mistaken identity, or drunk, or out of their minds." As elsewhere, the group then focuses in on the man, helping him to face the facts as a first step toward personal change. Once the offense is on the table, the group helps him explore the reasons for his offense. Along the way, changes begin to occur in his manner of relating to Dr. Steele, to other members of the group, and to the institution as a whole.

Most sex offenders are also assigned to an academic course, "Marriage and the Family," which seeks to explore the entire range of human sexuality and in particular to give the men some sense of female sexuality. The academic course, like the treatment program as a whole, is subject to a major disability: the absence of female participation except for Dr. Steele herself.

This disability, in turn, appears to be an inevitable result of the reformatory's geographical location. Buena Vista is a town with a population of 2,000, offering little opportunity to bring into the program either part-time female staff or women volunteers. The nearest large city or academic center is Denver, a five-hour round-trip drive over mountain roads when the weather is good—and with no alternative transportation. A visitor to Buena Vista finds it difficult to suggest ways in which the program could be enriched without moving it to a less isolated location. This handicap exacerbates the problem that the therapy sessions and sex education classes together occupy only a few hours of an offender's time per week.

Dr. Steele herself takes a realistic view of her program's shortcomings. Treatment at Buena Vista, she states, "has to be completed outside the confines of the institution, where the ex-offender has an opportunity to associate with women and to work out improved, realistic relationships with them. For this reason, all of the men who leave the program are referred for followup outpatient treatment in their own communities."

By September 1975, fifty sex offenders who had participated in Dr. Steele's program had been paroled and had lived in their communities for periods ranging from three to eighteen months. Letters to their parole officers, elicited followup reports on thirty-nine of the fifty. The results:

- 24 of the 39 men (61 percent) had remained free of any known criminal involvement.
- 13 men (33 percent) had committed no sexual offenses but had been involved in other kinds of criminal charges (such as theft, absconding, or robbery). Most of these charges were dropped or handled at the county level; only 3 of the 13 were back in state institutions.
- 2 men (5 percent) were convicted of subsequent

assaults on women. One was returned to the reformatory; the other was sentenced to the state prison.

The shortcomings of such follow-up studies are well-known and are discussed elsewhere in this study. They serve, nevertheless, to buttress two general findings from other follow-up studies: (1) sex offender treatment programs are not turning loose hordes of sex fiends to continue their sexual depredations on society, and (2) the recidivism rate for sex offenses is significantly lower than for crimes against property.

A.6. The New Jersey State Prison (Trenton) Program

The New Jersey State Prison is a maximum-security institution which receives only inmates whose maximum sentences run for 25 years or longer—though many, of course, are paroled in less than 25 years. Its treatment program, launched in the fall of 1974, is solely for rapists. Any rapist in the institution may volunteer for the program; to qualify, he must concede that he has in fact committed one or more rapes. Very few rapists apply for admission early in their incarceration; many have spent five or more years in the institution before applying. There are usually eight to ten rapists enrolled in the treatment group.

Limitations in staff time limit the program to one two-hour group therapy session per week. Frederick Rotgers, the institution's director of psychology who heads the program, concedes that this is much too little; he reports that the men themselves often request additional therapy sessions. Within those two hours a week, however, Rotgers believes that progress can be made in two essential directions.

One is a restructuring of the rapist's attitude toward women. Essential in this restructuring is the participation of women in the therapy. Two female clinical psychologists, Dr. Carol Gould and Ms. Ellen Collin, have served as co-therapists with Rotgers; and a social worker, Ms. Sally Schiedemantel, is also active with the group. Liaison is maintained with the Mercer Area (Trenton) Women Against Rape, affiliated with the National Organization of Women; women from this group on occasion visit with the rapists. For some of the men, the program offers their first experience in associating with women as equals on a basis of open communication. The changes in attitude which occur, Rotgers reports, are readily visible and may be highly relevant to the rapist's sociosexual adjustment following release.

The program has also contributed significantly to a more realistic understanding of rapists on the part of Women Against Rape. Women who spend a day rapping with the men in the Trenton program no longer have a vague stereotype of the rapist as a malevolent superman. Their hostility to rape remains unchanged, but they tend to see the rapist as also being a victim of a violent male-dominated society.

A second area explored in the group therapy sessions concerns the day-to-day problems of rapists lodged in a maximum-security correctional institution. By helping the men come to grips with the prison milieu, Rotgers believes, the program may set a pattern which will help them come to grips with the outside milieu following release.

Some of the men volunteer for the program because they believe participation may influence the parole board rather than because of any sincere desire to restructure their sociosexual attitudes. In several cases, indeed, men "volunteered" only after the board turned down their parole applications but told them that a subsequent application might be more favorably considered if they participated in the program. This tendency of inmates to "play the parole game" is sometimes cited as an argument against institutional therapy programs; how can a therapy group function effectively when participants are only there to "con" the parole board? Rotgers replies that when a group is functioning well, at least some of the men who originally volunteer as part of the "parole game" become genuinely caught up in the group process. Their attitudes toward therapy change—a harbinger of even more important changes in their attitudes toward rape, toward women, and toward their own life patterns. If those changes do not occur, the man is likely to feel himself an outcast in the group and to drop out.

Two hours a week of therapy, of course, cannot be expected to accomplish what can be accomplished during 168 hours a week in programs like Fort Steilacoom or South Florida. Nevertheless, the establishment of minimal programs on the Trenton pattern in other maximum-security institutions may be warranted. Rotgers reports, on two grounds:

- A minimal program addressed directly to the problems of sex offenders may be better than none at all.
- A minimal program may constitute an entering wedge for a more intensive program in the future.

A.7. Outpatient Treatment Clinic for Special Offenders, Baltimore, Maryland

This program, established in 1972, is patterned rather closely on the Philadelphia program (see pages 49–52).

The criminal court of the City of Baltimore is called the Supreme Bench of Baltimore; and the Supreme Bench maintains a Medical Service with a psychiatrist as Chief Medical Officer. For many years, this post was held by a nationally known forensic psychiatrist, the late Dr. Manfred Guttmacher, who had a special interest in sex offenders. His successor, Dr. Jonas R. Rappeport, who is also clinical associate professor of psychiatry at the University of Maryland, has continued that interest. In May 1972, Dr. Rappeport launched the Outpatient Treatment Clinic for Special Offenders at the University of Maryland's Institute of Psychiatry and Human Behavior, financed by a grant from the Governor's Commission on Law Enforcement and Criminal Justice to the State Division of Parole and Probation. Like the Philadelphia program, this Baltimore program offers to sex offenders generally the services ordinarily available only to wealthy defendants.

The Outpatient Clinic was set up to serve offenders referred by the courts of Baltimore, Baltimore County, and several surrounding counties. Since Dr. Rappeport was Chief Medical Officer of the Supreme Bench of Baltimore, and had been Court Psychiatrist for Baltimore County, Baltimore City and County judges lacked the common judicial distrust of psychiatric procedures; but referrals from other counties remain few. The Clinic also serves patients released on parole from Maryland correctional institutions; the State Parole Board makes these referrals, and there have been problems in the referral of unsuitable offenders and the failure to refer offenders who might benefit. As an independent institution, the Outpatient Clinic can—and does—refuse to accept unsuitable referrals.

The Baltimore program, like the Philadelphia program, has both a probation and a treatment component. Substantially all sex offenders accepted for treatment are assigned to a single probation officer; since July 1973 this officer has been Senior Probation Officer Paul Sivert, whose office is in the clinic and who administers the clinic as well as providing liaison with other probation officers. Several probation officers have served as co-therapists in the program for periods of six months or longer—as part of their advanced training. These techniques of assigning sex offenders to a specialized probation officer, using the sex offender treatment program as a training site for probation officers, and maintaining close rapport between treatment program and probation services are heartily recommended to other community treatment programs.

In addition to sex offenders, the Baltimore program is addressed to a particular subgroup of violent offenders—those who are not part of the criminal subculture but who on occasion suffer bouts of explosive-assaultive behavior. The two types of offender are treated separately; this description is concerned solely with the sex offenders.

Like Dr. Peters in Philadelphia, Dr. Rappeport initially sought to divide referrals to the clinic at random into a group receiving treatment and a control group receiving probation services only. The effort failed. Judges often insisted that particular offenders receive treatment as well as probation; this by itself destroyed the principle of random assignment. In addition, the members of the clinic staff sometimes concluded that certain patients required treatment and should not be assigned at random to a non-treatment control group. As a result, the effort to make a controlled evaluation was abandoned.

During its first three years the clinic provided treatment for 45 sex offenders, of whom 29 were in treatment in June 1975. Of these, 12 were exhibitionists convicted of indecent exposure, 12 were convicted of sexual assaults, and one each was in treatment following conviction for peeping, attempted arson, incest, sodomy, and "perverted practice."

Clinic sessions are held on the University of Maryland's Baltimore campus; the university provides space and administers the program's finances. The sex offender groups meet one day a week, from 5:15 to 6:45 p.m.; attendance is compulsory and repeated absence may be deemed a violation of probation—though this sanction is rarely invoked. Participants are charged from $1 to $5 per session, depending on income; there have been problems in collecting and the fees are a very small part of the total clinic costs. The goals of treatment are described as (1) helping participants achieve greater awareness of their problems, and (2) helping them attain sufficient control over their impulses so that antisocial acting-out behavior will not recur.

An evaluation of the program by its assistant director, Dr. James E. Olsson, was made for the three-year period ending in mid-1975. Dr. Olsson concluded that the sex-offender program was more effective than the program for assaultive offenders,

and that the recidivism rate for sex offenders was comparable to that reported by other treatment programs. As in Philadelphia, significant changes were noted in the attitudes and behavior of most participants as treatment progressed.

A.8. Program of the University of Southern California Institute of Psychiatry and Law, Los Angeles

Dr. Seymour Pollack is a psychiatrist and psychoanalyst whose field of major interest has long been forensic psychiatry—that is, the role of psychiatry in advising the criminal justice system. As director of the Institute of Psychiatry and Law at the University of Southern California, he taught this subject to psychiatrists in training; and through a series of workshops and seminars, he brought together judges, attorneys, legislators and others to explore problems in forensic psychiatry with himself and with other specialists.

Both defense lawyers and judges through the years frequently enlisted Dr. Pollack's services to examine a defendant and answer relevant questions: Is this person sufficiently sane to stand trial? Was he or she sane at the time of the offense—or should a defense of insanity be accepted? Is this person safe to be at large? In need of psychiatric treatment? Likely to reoffend? A danger to the community? With respect to sex offenses there was another crucial question: Is this person a "mentally disordered sex offender" (MDSO) within the meaning of the California sexual psychopath statute? Public defenders with indigent clients could also secure Dr. Pollack's services on such issues.

In California as elsewhere, this whole area of forensic psychiatry was in a state of disorder, with no common body of agreement among psychiatrists themselves and grave difficulties of communication among the lawyers, judges, and psychiatrists concerned in particular cases. These difficulties were peculiarly visible with respect to sex offenses. One psychiatrist, for example, might conclude that an offender was an MDSO because he believed the man needed psychiatric treatment—even though he represented no substantial danger to the community. Another psychiatrist might apply the MDSO label only to men so highly dangerous and so severely psychotic or otherwise deteriorated as to leave little hope that treatment would be of any use. Dr. Pollack's Institute of Psychiatry and Law did its best to resolve such disagreements and to establish agreed-upon approaches and procedures—notably during a week-long "Institute on the Sex Offender and the Law" held at U.S.C. in August 1972. The 709-page manual prepared for that seminar sought to bring together from a variety of sources relevant data and insights on all aspects of the sex offender; it has, unfortunately, not been published.

On countless occasions, when preparing a report on a particular sex offender for a judge, a practicing attorney, or a public defender, Dr. Pollack became acutely aware of an unmet community need. The offender he was examining, Dr. Pollack often concluded, was in need of psychiatric treatment but not in need of incarceration. Serving a term in the county jail, in a state correctional institution, or locked up in Atascadero State Hospital might considerably worsen his condition, and make recidivism more likely. The proper approach was clearly visible: a period of probation with psychiatric treatment as a condition of probation. The same kind of case repeatedly surfaced during Dr. Pollack's 1972 "Institute on the Sex Offender and the Law."

If the offender was well-to-do, the recommendation for treatment without incarceration made sense. A wealthy offender could almost always find a psychiatrist interested in his kind of problem and prepared to accept him as a patient. Few sex offenders, however, can afford intensive private psychiatric therapy. In 1973, accordingly, Dr. Pollack took the next step. Just as his Institute of Psychiatry and Law had long been examining and making recommendations concerning sex offenders without regard for ability to pay, so after 1973 the Institute began accepting a limited number of selected sex offenders for outpatient treatment without regard for ability to pay.

During the three years since then, scores of offenders have received treatment at the Institute. Major reliance is placed on group therapy, but with individual therapy available as needed. Several members of the Institute staff assist in this therapy program—including, since 1975, Dr. Alan S. Goodman, the clinical psychologist who had developed the communication-skills program under Dr. Michael Serber at Atascadero State Hospital (see page 43).

The treatment services offered at the Institute can be described as highly skilled but minimal. Some of the services available at the two more fully developed community programs in Santa Clara County, California, and Albuquerque, New Mexico, (pages 25 and 36) are lacking. Sex education and training in sociosexual skills are obvious examples. The University of Southern California program, nevertheless, may well serve as an *initial* model for other

community programs—providing for sex offenders in general, a treatment program without incarceration of the kind still available only to well-to-do offenders in many communities.

A.9. The Denver Program

Like the University of Southern California program, the Sex Offender Treatment and Evaluation Program of Denver's Violence Research Center was designed to make therapy available in the community without regard for ability to pay. Its origins, however, were quite different.

Denver General Hospital is a public hospital serving Denver's inner-city area. As far back as 1966, 50,000 patients a year were coming to Denver General's Emergency Room—5,000 of them for the treatment of psychiatric rather than medical emergencies. The largest group among these 5,000 were persons who had attempted suicide or were afraid that they were about to kill themselves. "An effort was made to refer these patients to local mental health centers," says Dr. James Selkin, a clinical psychologist then associated with the hospital's Emergency Room; but that effort "failed dismally." Fewer than one suicide-attempter in ten showed up twice following referral. "So then we developed a program with the Visiting Nurse Service in the city, and we began to serve suicide attempters by sending a visiting nurse to visit them in their home and talk to them and their families on the day following the suicide attempt. That program worked out quite well and is still in existence today.

"Some time after this, a youngster came to the Emergency Room following a sex assault, and she suicided a few days later." The community was aroused by this front-page event; and Denver's Department of Health and Hospitals responded by contracting with the Visiting Nurse Service to visit the victims of sex crimes as well as suicide attempters.

The data concerning the nature and consequences of rape which emerged from this program proved very rich; and Dr. Selkin, as head of Denver's Violence Research Center, subsequently made the findings available through a series of published and unpublished papers. One small example will illustrate the thrust of his approach. In Denver as in other large cities, rapes are far more common in the older sections of the city filled with substandard housing vulnerable to illegal entry. A rapist or burglar can secure entry into such crime-vulnerable buildings with little or no difficulty. "We develop housing regulations to protect our building against fire and against breakdown of electrical service and various kinds of structural collapse," Dr. Selkin noted, "but we have never developed housing codes to protect living units from crime."

Through interviews with women who had been raped and with others who had successfully forestalled or warded off rape, Denver's Violence Research Center was able to develop other suggestions for rape prevention. But one key body of data was missing: an intimate understanding of rapists themselves, which could hardly be secured through interviews solely with victims. A treatment program for rapists also seemed called for—and it could be justified as a community effort to lower the recidivism rate. The same logic should be equally relevant in other communities which have well-organized rape prevention services, rape education services, and rape victim assistance services—but which lack the fourth component of a comprehensive anti-rape approach, a treatment program for rapists and other sex offenders.

The Violence Research Center's Sex Offender Treatment and Evaluation Program, accordingly, was launched in November 1974, under the direction of a clinical psychologist, Dr. Harry H. Chapman, with a one-year grant from the Denver Anti-Crime Council. During its first eleven months it provided treatment for 45 sex offenders—including 18 rapists and 11 persons guilty of "sex assault," five exhibitionists, four incest offenders, and seven offenders of other types. Though some offender group sessions were scheduled, primary emphasis was placed on individual therapy—in part, no doubt, because the program remained small and professional, time was available for individual sessions; and in part because the yield of research data concerning the nature, motivations, and modes of operation of offenders might be richer.

A site visit was paid to the Denver program late in April 1976—but the program was discontinued a few days later when the one-year grant and its six-month extention expired. The need remains clear for other community programs which can become effective components—along with rape prevention, rape education, and services to rape victims—in a concerted community response to the sex offense problem.

In a 1976 paper summarizing the experience of the Denver program, Dr. Chapman made several points of general interest. In the Denver area, he noted, about one percent of all children are reported to suffer from child abuse (including sexual abuse). Among rapists and sexual assaulters in the Denver program, however, 56 percent reported having been

abused as children, and among other categories of sex offenders 36 percent reported having been abused. The Denver figures confirm the remarkable frequency of child abuse (including sexual abuse) in the case histories of sex offenders elsewhere.

The sex offenders in the Denver program, Dr. Chapman similarly noted, experience the same feelings as other people—feelings of anxiety, guilt, sadness, fear, self-distrust, worthlessness, and so on; but many of them lack the vocabulary necessary to identify these feelings verbally and to think about them. Because the feelings are unrecognized and unlabelled, they are not consciously associated with the internal and external events which trigger them. One of the Denver program's first goals, accordingly, was "to teach the patient how to recognize his own feeling states" and their origins. "The methods by which this was accomplished were purely didactic. For example, we might simply ask the patient to describe a recent incident in which he felt anxious, nervous, angry, uptight, or, more generally, just felt 'bad.' We then might ask him to visualize the incident in his mind and describe how he felt as he did this. We then would label the feeling for him, if he was unable to do so himself, and then generalized the label to other similar feelings and incidents in his experience." Further, a patient might be asked "to practice monitoring his own feeling states between sessions and then to describe at his next appointment what he did about them. When the patient achieved these simple skills, he could then discuss his feelings with significant others and with the project staff rather than act them out." In the process he also learned the kinds of incidents or events that tended to trigger negative feeling states. All this, of course, meant progress toward *impulse control*—that is, "the capacity to use cognitive skills to deal with problems rather than having to act out his feelings in a sexual assault."

As in other programs, the Denver program found that "underlying the feeling states of anxiety, anger, and/or depression seemed to be a chronic sense of low self-esteem; specifically, a basic sense of not being worthwhile. It appeared to be this underlying basic feeling of worthlessness that our patients were unable to tolerate; it was easier or more comfortable for them to experience anger and act on it than to experience the pervasive sadness that underlies their superficial behavior."

Before dealing with this sadness and sense of worthlessness, Dr. Chapman reports, the Denver program sought to help the patient develop a "conceptual framework" within which he could fit his life experiences and his responses to those experiences—so that his life would begin to make some sense to the patient himself. "When the patient had begun to utilize the framework in a way which enabled him to relate life events and feelings to it, then the therapist could begin to work with the patient in exploring his underlying chronic feelings of worthlessness and alternatives to them. Typically, this was the most painful time in therapy for the patient and a time when his emotional resources were most stressed. It followed that this was the period in treatment when the patient was the most likely to act out and the most dangerous of the offenders in the program were most apt to recommit their crime. It behooves the therapist to be alert to this and to encourage the patient to use his newly acquired controls instead of acting out. In some cases, medication or brief hospitalization was needed at this point. It was also true, in our experience, that once the patient grasped the significance, for him, of his underlying feelings of low esteem, he rather quickly made major changes in his relationship with others and in his lifestyle generally."

Dr. Chapman adds that this approach to the sex offender, though developed independently, closely parallels an approach described by Dr. John R. Lion in 1975 (see Bibliography) for violent offenders in general.

APPENDIX B. EVALUATION OF SEX OFFENDER TREATMENT PROGRAMS

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B.1. Problems of Evaluation

The preceding pages describe a large variety of relatively new treatment programs for sex offenders, especially what seem to be promising ways of making these law violators less prone to repeat their crimes. But the innovations can now be evaluated only by intuition, by whether we feel they make sense. It is impressive that at several centers offenders who have misused people and have little regard for themselves are inspired to help others in a responsible manner, and thereby develop more favorable self-concepts. It seems appropriate that heterosexual men who were inept in seeking feminine affection are instructed in social skills for developing better relationships with women, and that this is done with female staff and volunteers. It is logical that persons whose crimes apparently are related to their bitter fantasies about the psychophysiology of sexual arousal in women, or in some cases their panic at normal changes accompanying old age, are given realistic education in these matters.

Despite fine impressions and plausible justifications, no one can demonstrate with great precision and conclusiveness that these new programs are more effective in reducing sex crimes than traditional prisons or mental hospitals. Case illustrations of both success and failure in behavior change can be found among the graduates of every long-established facility for sex offenders. In the few instances where followup statistics are available that suggest a new program's alumni commit fewer crimes, it is not clear whether this is because the program actually works better or just receives cases that have better prospects.

Evaluation is the process of obtaining more objective and precise knowledge on what treatment works best for whom, and at what cost. Problems in collecting this information become evident in considering the four broad questions that will be addressed here: What are the goals of treatment and the indices of their attainment? What research designs are desirable and which are feasible? What distinctions among cases should be most relevant to treatment outcome? Who should assess whom? For reasons that will be indicated, in a majority of our states the answers to these questions are much more complicated for sex offenders than for other types of criminals.

B.2. Goals and Statistical Indicators of Their Attainment

Since a correctional agency is part of the criminal justice system and is given control over people only because they are convicted of offenses, its primary treatment goal presumably should be to reduce recidivism rates. Since a mental hospital is part of the public health system, its goal in patient treatment is to restore mental health, if possible. The fact that the sex offenders in many of the programs described in the preceding sections of this monograph are shuttled back and forth between the mental health and criminal justice systems complicates evaluation of their treatment. Most of these programs deal with persons committed in civil courts to state hospitals under what were called "sex psychopath laws" (but often have more euphemistic names now) that apply only to persons whom criminal courts convict of sex crimes.

About 30 states have some type of civil commitment law for convicted sex offenders, but no two of these statutes are identical. In a few states the law applies in principle to a broader range of criminals than sex offenders, to everyone whom some laws call "defective delinquents" regardless of age, but in practice even these statutes are used mainly for sex offenders. In several of the states with the most developed treatment programs, after someone is convicted of a sex crime the court may—and usually does—commit him (it is seldom applied to women) to the mental hospital unit treating such cases for 30 to 90 days of observation and diagnosis. If the

hospital deems the offender amenable to treatment, the judge usually commits him to it for an indeterminate period, sometimes with an upper limit, and usually with a minimum frequency of reporting on the patient's progress.

Even after an offender receives civil commitment to a state hospital and treatment has been attempted for months or years, the hospital can in some states return him to the court with the diagnosis that he is unamenable to treatment, often also advising whether he is "sexually dangerous" or, in California, a "mentally disordered sex offender." Whenever a patient is returned to court, whether after the diagnostic period alone or after treatment beyond that, the judge—not bound by the hospital's diagnosis or recommendation—can decide to impose a prison sentence because the crime was serious and the man is regarded as dangerous; alternatively, the judge may release him, either dismissing the case or placing the man on probation, often because the involuntary confinement already imposed in a hospital and perhaps pretrial in jail is deemed more than sufficient retribution for the crime. Thus a person convicted on misdemeanor charges for sexual peeping or exhibitionistic "flashing," with many prior convictions for the same offense, who shows no insight or cooperation in treatment, may be returned to court by the hospital as unamenable, but may then be released as confined already more than the criminal code's maximum penalty for the offense. Yet if the hospital deemed him amenable, it might hold him months longer for further treatment. Ultimately the court, or in some states a parole board or a hospital board, decides on the release of an offender from hospital treatment, and sometimes at a later date, on discharge from aftercare or from parole in the community.

These many types of decision, each an exercise of much discretion by judges or others, create a large variety of possible error rates that should be estimated for comprehensive evaluation of such programs, as all are related to the goals of reducing recidivism and improving mental health. Such rates include: (a) the percentage committed to hospitalization who later are judged unamenable and returned to court for a new disposition; (b) the recidivism rate for those deemed unamenable and dangerous but released; (c) the recidivism rate for those deemed unamenable but nondangerous and immediately released, compared to those with the same diagnosis jailed or imprisoned before release; (d) for those deemed amenable, the recidivism rate when treated in the civil commitment program compared to the rate when not committed to this program but jailed, imprisoned or placed on probation; (e) for those treated then released, the recidivism rates for different categories of assessment of treatment progress; (f) a variety of rates other than recidivism from followup of cases after release, such as later psychiatric diagnoses, personality test scores, divorce rates, rates of disruptive use of alcohol or drugs, unemployment rates and other data reflecting treatment goals; (g) a breakdown of recidivism into separate rates by sex crime and other offense, or by particular types of sex crime or other infraction.

Quite different but also diverse goals may be pursued simultaneously when offenders are on probation with the stipulation that they participate in psychiatric treatment or conform to other probation conditions. Unique goals also are associated with particular types of offense. Thus in Santa Clara County's distinctive program for incest cases, described in Sections 2.9 through 2.15, attainment of various goals may be indicated by such measures as: (a) percent of families who participate in the program; (b) attendance rates in psychiatric outpatient treatment for the father and sometimes for other family members; (c) rates of participation by fathers and mothers in Parents United; (d) rates of participation by daughters in Daughters United; (e) percent of families that live together after the daughter initially is placed in a foster home; (f) incest recidivism rates; (g) incest recidivism rates separately for those families that participate in the program (reported to be zero for the more than 90 percent that do) compared with these rates for nonparticipants; (h) marriage and divorce rates for girls involved in incest and divorce rates for their parents, compared to averages for women in the county who are similar in age and other demographic characteristics; (i) probation violations other than incest.

For heterosexual offenders—such as rapists, about 90 percent of child molesters, and almost all exhibitionists and voyeurs—a goal of many of the treatment programs described in preceding sections is to increase social and sexual skills in dealing with women. One measure of attainment, described in Section 4.10, is a rating form developed by Dr. Gene G. Abel at the Tennessee Psychiatric Hospital and Institute in Memphis, which is scored by observers of videotapes made when the clients were conducting conversations with women therapists or volunteers. Also employed at this center and elsewhere are penile transducers which measure the rates of male genital response to various legal or illegal stimuli, for example, attractive adult women or small children.

The validity of these measures for prognosis of normal or deviant sexual conduct can be determined by also procuring the ultimate criteria of treatment outcome, rates of sex offense recidivism after release, and possibly marriage and divorce rates.

Sometimes a change in public attitude and in the criminal law can alter the goals of a sex offender treatment program. Thus Section 3.2 indicates that at Atascadero State Hospital in California, anticipating the 1976 change in California statutes which decriminalized homosexual acts between consenting adults in private, the previously futile efforts to change those convicted for homosexual acts into heterosexuals or asexuals were abandoned. Instead, persons associated with the Gay Liberation Movement were brought in to teach these patients how to be homosexuals legally by seeking amorous contacts or conducting sex acts more discreetly, and only with adults; goal attainment with them is indicated by low rearrest rates.

Obviously, all the goals mentioned require assessments of change over time. This raises questions of short-term versus longrun evaluation. It is best to get both. Short-term followup data are attractive because they give prompt feedback; they show outcome of treatment under conditions and with programs generally not as different from those current as are assessments of outcome for clients released five or ten years ago. Long-term evaluations can inspire greater confidence in the validity of conclusions on effectiveness; also, the correlation between short- and long-term findings indicate how much faith can be placed in early results. If long-term evaluations indicate that treatment reduces recidivism rates, they permit estimates of the financial savings achieved by diminishing rearrests, new court proceedings and correctional services, as compared with the cost of effective treatment in the first place. Legislators and other funding decision-makers often are more impressed by a cost-benefit assessment in terms of dollars than one in terms of human suffering averted or happiness attained.

The data needed for the various types of measure described here have multiple sources of diverse adequacy. Recidivism rates of released sex offenders can be tabulated from information on rearrests procured from local police or probation offices, and local court records may show reconvictions. A more adequate check is provided by current criminal record forms (rap sheets) from state criminal identification bureaus or, if available, from the F.B.I. Supervision data from probation or parole offices may also be useful. If resources permit, it is best to get and compare criminal records from all these sources; it usually is presumed that state arrest reports include local as well as other arrests, but often the local record is not fully included in the state document due to incomplete reporting or recording, confusion of identities from aliases, and other sources of error.

Any official criminal record usually is incomplete, of course, since it does not include offenses for which the offender was not caught. Therefore, it is most important in evaluation by recidivism rates to use the same sources of criminal record information for all groups compared—for example, those in a special treatment program and similar offenders not in it. It is then assumed that the proportion of error in recidivism rates is about the same in each group; thus, an appreciable difference in official recidivism rates of two large groups presumably shows that they actually have different postrelease crime rates, because the recidivism of each group is underreported to about the same extent.

Information on family relationships, employment, attitudes or sexual conduct not reflected in the criminal record, and even details on crime, often require locating the subjects for interviews and perhaps also talking to other people in their households. But such contacts are routine in the course of surveillance and assistance by probation, parole and aftercare officers. Sometimes clients receiving postrelease supervision are required to submit much information relevant to evaluation, such as their employment and family status, in monthly reports. If all cases compared for an evaluation study are released under these conditions throughout the followup period, and if supervision records and client reports are complete and standardized, they may suffice for most evaluation studies. Therefore, to institutionalize routine feedback on the effectiveness of treatment efforts, the most efficient procedure is to make research and supervision records identical. For this purpose it is desirable that research personnel work with supervision officers to develop efficient standardized forms, and that supervision recordkeeping be somewhat monitored thereafter to assure that complete and accurate entries are always made in them.

B.3. Desirable and Feasible Evaluation Research Designs

Evaluation always is done by making comparisons of goal attainment in one group with goal attainment in another group, or in some circumstances, of the

same group's attainment at different times. For example, a type of treatment is evaluated when postrelease record of offenders receiving it is compared with that of similar offenders not given it.

Sometimes all that is available are followup data on a treated group—so-called "one-shot followup data," such as the 6 percent recidivism of sex offenders in Wisconsin cited in Section 3.1. Then the only comparison that can be made is with what is imagined would be the record for an untreated group, such as the cited recidivism rates of non-sex offenders in Wisconsin. Unfortunately, it often is hard to be confident that two groups for which we can procure postrelease data are comparable, and in the Wisconsin example they clearly are not. But, when we can show that sex offenders in one of the programs described on the preceding pages have lower recidivism rates than those excluded from it, does this prove that the program was effective or that it only received the best risk cases, those who would have low recidivism rates with no treatment? Is a program's success rate due to the treatment it provides or to its selection of cases?

There are a number of alternative methods for making comparisons in order to evaluate programs. All have some advantages and some disadvantages. Usually not all are feasible. Therefore, it is appropriate to be familiar with all of them, so that the best method possible under the circumstances can be used, and its limitations known. Confidence in a generalization on the effectiveness of a type of treatment for a kind of offender is greatest when it is the conclusion supported most consistently by different varieties of research in diverse settings.

B.4. Controlled Experiments

The ideal evaluation design, in many respects, is the classical controlled experiment. For example, if there are twice as many offenders eligible for a treatment program as it can handle, make lists of all those eligible and divide them randomly, admitting half to the program to comprise the treatment or experimental group, the other half being the control group. It need not be exactly half, provided there are appreciable numbers in both groups, if a purely randomizing method (such as a statistician's use of a table of random numbers) is the basis for assignment of some to treatment and some to control.

There can be maximum possible confidence that experimental and control groups are similar in every respect except whether or not they participated in a treatment program to be evaluated, if: (1) these two groups are quite large—for example, several hundred in each—as the larger the groups the smaller the probability of significant differences between them; (2) there is no interference at any time in the purely random separation; and (3) all the experimentals get the treatment and none of the controls receive it. The laws of probability dictate that under these circumstances not only identifiable traits, such as age or offense, but even subtle personality differences only surmised by intuition or unknowable personal characteristics, will be about equally distributed in the two groups.

Whenever there are suspicions that chance may have caused important differences between randomly selected treatment and control groups, as can readily occur if they are small, the groups can be compared on whatever objective characteristics are readily tabulated from the records, such as the percentage in every age, offense, or ethnic category. If this check is made before the assignments to the treatment program are announced, assignments can be revised by randomly selecting cases from each group to transfer to the other until similarity in the proportion of each of these key characteristics is achieved in the two groups. Preferable, however, is assurance of similarity in advance by using stratified random sampling procedures to assign people. Thus all eligible offenders can first be divided into subgroups by variables about which one is most concerned, such as age or offense or some combination of these and other factors, and then each subgroup can be randomly divided into a treatment and a control group. The next section will discuss the variables that research and theory suggest are most relevant to treatment amenability in sex offenders.

In practice, many developments impede use of a controlled experimental design in evaluation: (1) Some offenders on their own initiative, or through staff interested in them, thinking the treatment is desirable, surreptitiously get transferred from control to treatment, or protest their exclusion so effectively that they are transferred, or participate in the treatment even though they are in the control group (the interference of a judge with a controlled experiment in Baltimore was cited in Section 4.3). (2) conversely, some think the treatment will be stressful or will result in longer confinement, whether true or not, and evade participation in it. (3) staff with a vested interest in a program, wanting its evaluation to be favorable, interfere with the randomization procedure to get the most promising cases into treatment and the worst ones out. (4) some individuals object, on civil rights grounds, to any random assignment of

humans as undignified, even when there is no conclusive evidence that deliberate selection for the treatment can be based on valid judgment unless it is evaluated rigorously (they want the treatment either given to everyone or some nonrandom method used in assigning people to it). (5, there is the so-called "Hawthorne Effect," whereby people in any special program have unusually good morale and "try harder," so the success rate with the experimental group is not sustained when the treatment becomes routine. (6) administrators accustomed to transferring patients or clients on the basis of expediency, to keep all work or residence space full, or to keep their clients happy if they request a change, ignore experimental research directives, often without notifying the office responsible for evaluation. (7) there just are not enough sex offenders in the organization at a particular location to permit a meaningful random division, and they are received by ones or twos every few weeks, so they are absorbed into whatever treatment program seems appropriate and available at the time, if they are interested in it.

All the above obstacles also impeded the development of experimental medicine. Sometimes they occur only on a small scale and can be taken into account in analyzing results. Most of the time, however, they preclude the possibility of evaluation by controlled experiment and alternative designs must be attempted, often called "quasi-experiments."

B.5. Employing Comparison Groups

If random division of sex offenders into experimental and control groups is not feasible, goal attainment rates of those in a treatment program can be compared with the rates of what are presumed to be similar offenders treated much differently. These comparison or "quasi-control groups," most often consist either of the sex offenders dealt with by the same agency before the treatment program was introduced, or of sex offenders in another agency—perhaps in another city or state—where the type of treatment program being evaluated does not exist.

The obvious risk in quasi-experiments, as compared with classical controlled experiments, is that the treatment and comparison group may differ in respects that significantly affect the goal attainment measured, perhaps more than does the treatment. Thus sex offenders dealt with previously or in another city may be a different mixture due to variations in legislation, or in police or court policy, that determine what fraction of all sex offenders get caught and convicted. The offenders may differ in the extent to which they have group support or stigma, due to variations in group norms such as those on homosexuality.

When the subjects being treated have a long history of repeatedly committing the same offense, they can be their own comparison group; their crime rates in a several year period before participating in the treatment can be compared with their offense rates afterwards. Of course, this may be biased by a tendency for most offenders to "mature out" of their crime, for their recidivism rates eventually to taper off as they grow older (although not so true for some sex crimes). If traditional patterns of tapering off with age can be compared with the pre- to post-treatment change of the evaluated group, it may be possible to judge whether the latter change is greater than can be accounted for just by aging. Indeed, if the sample studied includes subjects of considerable range in age and all age levels show similar tapering off following treatment, one may have confidence that the program is having an impact. Pre-post comparisons of offense rates or other characteristics, such as employment or addiction, can be combined with controlled or quasi-controlled experiments, since the pre-post data can be collected for both the treatment group and the control or comparison group.

When it is evident that a treatment and a comparison group differ, and sometimes even if they are identical—when they are ideally randomized control groups—it is desirable not to compare all offenders participating in the treatment with all who do not, but to make separate comparisons for each important type of offender represented in both groups. Thus one can determine goal attainment rates for rapists with and without treatment, for child molesters, and so forth. The objective is to determine what types of treatment work best for what types of client.

B.6. Differences That Make a Difference

Sex offenders are an extremely diverse group. The kinds of persons who commit each major type of offense that sends people to the special treatment programs described in this volume usually are quite different. Indeed, few individuals commit more than one of these types of sex crime, although many often repeat their particular kind of law violation. Furthermore, there is appreciable variation within some of these separate offense groups.

Exhibitionists practically never have a history of rape or of much other crime. Although they startle

women by "flashing," they appear to be rather timid towards them in most situations, and not aggressive towards men. Voyeurs—Peeping Toms—usually are thought of as the most passive sex criminals in their offense, but a record of rape was found in about ten percent of them in the largest study of sex offenders yet undertaken, begun by Kinsey and completed by Gebhard and associates after Kinsey's death. Most peepers had been unspecialized delinquents, with a record of burglary quite frequently, and peeping by some may have been done only when they happened upon an attractive sight while prowling for burglary or even rape opportunities. Most peepers, however, were more passive sexually. Until our very limited knowledge is enhanced by more rigorous statistical research on these two types of offenders, it seems appropriate to investigate treatment outcome separately on each.

Incest is a unique type of offense, best comprehended by study and treatment of all family members involved. Therefore, as indicated earlier, treatment evaluation for them may require distinctive types of data and where they are treated with other sex offenders, it seems appropriate to assess effectiveness separately for them.

Child molesters are a rather mixed group. About half the arrestees only fondle the child, but it usually is alleged that in doing this they touch breasts or genitals, while the rest go further; some attempt coitus, others commit fellatio or persuade the child to do it to them. They are of a very wide range in age, from adolescents to old men. About a third are involved only with children who are strangers to them and they usually confine themselves to fondling, while those engaging in coitus or fellatio are more often of the same household or a neighbor of the child.

Child molesters have very high recidivism rates on parole in most state correctional systems, but some civil commitment programs emphasizing psychotherapy and sex education, such as California, claim that these offenders have low recidivism rates. This contrast suggests that child molesters are particularly amenable to treatment, and therefore, that evaluation efforts should attempt to make separate assessments of their responses to alternative programs, rather than group them with all other sex offenders in estimating treatment effectiveness. Nevertheless, further distinctions seem appropriate if the number of cases permit, between child molesters who only fondle children who are strangers to them, and those involved in more extensive and continuing genital activities with youngsters whom they see frequently. Classifying them in age groups also should be useful, since one would expect different styles of treatment to be optimum for those under 30, for example, than for those over 50.

Rapists vary considerably by the extent of their record in other crime and delinquency. The unspecialized offenders have a fairly high rate of recidivism by other types of crime, rather than by rape. Those convicted only once for rape generally are very good risks on parole without any special treatment. There are grounds for some research for expecting the rapist with a prior history of participation in delinquency and youth crime of various sorts to have a higher recidivism rate from psychotherapeutic programs than from traditional corrections, trade training and halfway house release. Thus distinctions should be made among rapists by type of prior criminal or delinquent record, if any, assessing treatment effectiveness for them separately.

B.7. Who Should Evaluate Whom?

Although the public's goals in sex offender treatment programs, such as reducing recidivism and improving skills and attitudes of clients, will be voiced by program administrators, in practice their conduct is often guided as much or more by other goals. These include: (a) maximizing rewards and security in their jobs; (b) reducing stress in their work; (c) procuring public support and funding for their agency; (d) maintaining staff morale; (e) keeping clients contented. These staff goals, of course, are not necessarily incompatible with each other or with public goals, although they may be at times, and they may also conflict with the public's interest in obtaining valid evaluations of the attainment of its goals.

Some problems from administrators already were indicated in discussing the feasibility of research designs. Frequently the priority they give to administrative convenience, favorable evaluations, or satisfying clients, lead to their impeding not only controlled experiments, but data collection of many types for all varieties of evaluation. Researchers assessing a treatment program need rapport with staff, however, for the evaluators must observe the treatment activities, and interview clients and staff, to ascertain that what is claimed is the type of treatment conducted actually is going on. Their reports to evaluate a treatment program by followup of clients also should, as objectively as possible, describe the frequency and quality of participation in the treatment effort; as indicated in discussing treatment goals, such participation comprises a separate

goal that merits evaluation. In all such inquiries, treatment staff have both an interest and possible conflicts of interest.

To maximize the validity of evaluations it is desirable that researchers be familiar with the treatment being assessed, yet have autonomy in assessing it. They need good rapport with the treatment personnel, administrators and clients, yet must be responsible to a higher office of government, to the faculty of a university, to an independent research foundation or to the board of trustees of a private treatment agency, for the accuracy of their feelings. The affiliation of researchers often influences the cooperation they receive in a treatment center, the priority they give to different topics of inquiry, and the promulgation of findings that they favor. All these considerations, plus the size and resources of a treatment agency, and the treatment goal attainment that is to be measured, may determine an optimum answer to the question of who should conduct an evaluation.

In today's era of scientific perspectives, and of strict accountability expected from those who expend public funds or control the liberties of people, interest in making systematic inquiry and obtaining objective answers should begin with the treatment center directors. Often they can conduct small-scale evaluation studies, not so much of their program as a whole as of specific practices and procedures. Thus the topical focus of group therapy sessions and the participation it evokes from various clients can be systematically tabulated from tapes, questionnaires can periodically summarize client and staff reactions to various features of a treatment program, and extension of such surveys to successful alumni may reveal the aspects of a treatment program that rehabilitated offenders find most useful in their subsequent lives.

Treatment center directors, however, usually are so preoccupied with the daily pressures of operations, with making today's program work and solving quickly any immediate problems, that they cannot be depended on to give even research they desire the regular concentration it requires. They, therefore, tend to start or merely contemplate more research than they complete, and drift into assessing their operations by impressions. In such impressions, however, the loudest voices get the most attention, and cases or events that confirm their prior opinions or preferences become the basis for their generalizations.

Without systematic studies, that which is cited to justify policies and practices is often unrepresentative, and masks reality. Administrators are especially likely to avoid the kinds of situations that give them "trouble," that caused stress for them, and to base their policy on avoiding recurrence of the episodes that they talk about for years. Often this habit leads to a resistance to change and to avoiding undertakings that would increase their contribution to societal goal attainment, such as recidivism reduction.

There is no simple formula for assuring regular guidance of practice and policy by feedback from research, but the best guarantee is to have a long-established full-time research staff at an office higher up in the government hierarchy than the immediate treatment center. The research office should be at a level of government high enough to support it, to give it some autonomy and to cause treatment center directors and staff to feel obliged to cooperate with it in evaluations.

Staff of an evaluation research office will be most effective if not only well-trained, but if oriented to their job as a career rather than as an adjunct to their graduate study or movement to a university faculty. Staff ability is proven not so much by academic laurels as by completed research reported in a manner that both administrators and the public can understand and appreciate, yet scientifically acceptable to sophisticated academics. Persons who have had scientific training but have been long preoccupied in administrative or clinical work often prove unsuccessful in shifting late in life to a research position, though there are exceptions; on the other hand, people who have worked in treatment agencies while training for research, then soon move into full-time research, often retain the rapport and understanding of treatment clients, staff and circumstances that can make their research concerns most relevant and valid. They can also work well to institutionalize evaluation by developing and monitoring, in collaboration with treatment and operations staff, records that serve the needs of all these specialties simultaneously, and most efficiently.

Research corporations, foundations and institutes, as well as universities, are especially useful for one-time evaluation studies to address basic theoretical questions or guide future agency research. Universities have interests in testing theoretical explanations for sex offender conduct and explaining why particular modes of treatment are effective or ineffective, that go beyond evaluation and are most likely to suggest imaginative new approaches. University personnel also are expected to be on the forefront of international accumulation of knowledge, and thus be familiar with innovations, theory, and research

developed elsewhere that may be fruitful locally. To maximize the contribution of each to the improvement of treatment services, continual communication should be structured, formally and informally, among treatment center personnel, their supervising higher officials of state or local government, interested university specialists, and evaluation researchers at all levels.

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Appendix A. Nine Additional Treatment Programs

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Appendix B. Evaluation of Sex Offender Treatment Programs

B.1.–B.5. Evaluation of Sex Offender Treatment Programs

Glaser, Daniel. *Routinizing Evaluation: Getting Feedback on Effectiveness of Crime and Delinquency Programs*. National Institute of Mental Health, Center for Studies of Crime and Delinquency, DHEW Publication No. (HSM) 73–9123. Washington: U.S. Government Printing Office, 1973. 202 pp.

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PRESCRIPTIVE PACKAGE: "Treatment Programs for Sex Offenders"

To help LEAA better evaluate the usefulness of Prescriptive Packages, the reader is requested to answer and return the following questions.

1. What is your general reaction to this Prescriptive Package?
   [ ] Excellent [ ] Above Average [ ] Average [ ] Poor [ ] Useless

2. Does this package represent best available knowledge and experience?
   [ ] No better single document available
   [ ] Excellent, but some changes required (please comment)
   [ ] Satisfactory, but changes required (please comment)
   [ ] Does not represent best knowledge or experience (please comment)

3. To what extent do you see the package as being useful in terms of: (check one box on each line)

	Highly Useful	Of Some Use	Not Useful
Modifying existing projects	[ ]	[ ]	[ ]
Training personnel	[ ]	[ ]	[ ]
Adminstering on-going projects	[ ]	[ ]	[ ]
Providing new or important information	[ ]	[ ]	[ ]
Developing or implementing new projects	[ ]	[ ]	[ ]

4. To what specific use, if any, have you put or do you plan to put this particular package?
   [ ] Modifying existing projects
   [ ] Administering on-going projects
   [ ] Others:
   [ ] Training personnel
   [ ] Developing or implementing new projects

5. In what ways, if any, could the package be improved: (please specify), e.g. structure/organization; content/coverage; objectivity; writing style; other)

6. Do you feel that further training or technical assistance is needed and desired on this topic? If so, please specify needs.

7. In what other specific areas of the criminal justice system do you think a Prescriptive Package is most needed?

8. How did this package come to your attention? (check one or more)
   [ ] LEAA mailing of package
   [ ] Contact with LEAA staff
   [ ] LEAA Newsletter
   [ ] Other (please specify)
   [ ] Your organization's library
   [ ] National Criminal Justice Reference Service

(CUT ALONG THIS LINE)

9. Check ONE item below which best describes your affiliation with law enforcement or criminal justice. If the item checked has an asterisk (*), please also check the related level, i.e.

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[ ] Crime Prevention Group *	

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